1995

Comment Letters to proposed audit and accounting guide: Health Care organizations;

American Institute of Certified Public Accountants. Accounting Standards Executive Committee

List of Respondents to the Proposed Audit and Accounting Guide
Health Care Organizations

Letter Number	Commentator
1	Children's Hospital of Philadelphia
2	John Singer -- Singer Richardson, Neuman, and Stringer
3	Devereux
4	Veterans Memorial Medical Center
5	Northern Illinois University
6	Benjamin Podger
7	The Detroit Medical Center
8	George Tayar
9	Managed Care Re
10	Managed Care Re
11	Ron Kovenor
12	Massachussetts Society of CPA's
13	Richard J. Serluco & Co.
14	Stanley F. Dole
15	H. Selwyn Torrence
16	Moody's Investment Service
17	Masonic Homes

18	The St. Joseph Health Care System
19	The Kendal Corporation
20	Harvard University
21	Hospital of Saint Raphael
22	Fitch Investor Service
23	Sisters of Mercy Health System
24	HFMA
25	Adventist Health System
26	Yale New Haven Hospital
27	New Jersey Society of CPAs
28	Ron Kovenor
29	Arthur Anderson
30	Multi-Care Health System
31	Governmental Training Solutions
32	Allina Health System
33	Abraham D. Akresh, CPA
34	Louisianna Society of CPAs
35	New York Society of CPAs
36	Charter Medical Corporation
37	Deloitte & Touche

38 Illinois CPA Society

39 Ernst & Young

AICPA
American Institute of Certified Public Accountants

INTERNAL MEMO

Date: September 14, 1995 Reply:

To: Leonara Lemantia, AICPA Library

From: Annette Schumacher Barr

Subject: Comment Letters on Health Care Audit Guide Exposure Draft

Enclosed are copies of the 39 comment letters received to date on the exposure draft of the proposed Audit and Accounting Guide *Health Care Organizations*. Please make these letters available for public inspection. Thanks!

FOUNDED 1855

THE CHILDREN'S HOSPITAL OF PHILADELPHIA

34th STREET AND CIVIC CENTER BOULEVARD•PHILADELPHIA, PA 19104•(215) 590-3742
FAX # (215) 590-3299

LOUIS G. TROILO
VICE PRESIDENT-FINANCE &
CHIEF FINANCIAL OFFICER

April 6, 1995

Bill Fingland, Chairman
AICPA - Healthcare Task Force
Harborside Financial Center
201 Plaza III
Jersey City, NJ 07311-3881

Dear Mr. Fingland:

I would like you to rescind your recent proposal to eliminate non-operating information from not-for-profit healthcare reporting standards. Actually FASB No. 117 should be rescinded for not-for-profit healthcare institutions. To include hospitals in the same category as museums, American Cancer Society and other like organizations is both inane and illogical.

For years hospitals have been encouraged to operate as a business and to report financial information accordingly. Within the last 15 years significant strides have been made in more uniform and understandable reporting of healthcare financial reporting. This is especially evident with the reporting and scrutiny of financial information presented in connection with the huge amount of debt offerings which have occurred.

Having been a participant in that debt process, I know that rating agencies, investment bankers and investors were all able to understand our financial statements. I know that will not be the case once these new standards become effective since I can't even figure out how to report all our different restricted funds under these new rules. Even our auditors are grappling with how to present meaningful and understandable financial statements under the new rules.

The new standards require reporting of expenses by program versus natural classifications and an example was given. Professional care of patients was listed as an expense line item. Classification of what expenses relate to professional care of patients can be quite arbitrary and will result in less comparability than more. Also, dietary was listed as an expense line item. I am sure investors are hungering for that information.

I could go on and on but the bottom line (even though there is no bottom line only an increase or decrease in unrestricted net assets under the new rules) is that FASB No. 117 along with the AICPA's interpretation is totally inappropriate for healthcare institutions.

Please reconsider and revert to what makes good sense.

Sincerely,

Louis G. Troilo

LGT/dm

cc: Dennis R. Beresford, FASB
Patricia Hlavinka, HFMA

Singer, Richardson, Neuman & Stringer

A Registered Limited Liability Partnership Certified Pu

Members:
American Institute of CPAs
Texas Society of CPAs

May 4, 1995

Ms. Annette J. Schumaker, Technical Manager
File H-1-500, Federal Government Division
AICPA
1455 Pennsylvania Ave., NW
Washington, DC 20004-1081

Re: Exposure Draft
Health Care Organizations

Dear Ms. Schumaker:

Our firm represents numerous home health agencies throughout Region VI. Revenue derived under federal and state third-party reimbursement programs in this region is greater than 90% in most agencies. The current audit and accounting guide and the exposure draft seems to indicate that revenue can only be presented as net patient service revenue to be in accordance with standards established by the AICPA.

Our firm, clients and creditors have found the Statement of Revenue and Expenses more informative when gross revenue, contractual adjustments, and net patient service revenue are presented. My question is, can the statement disclose gross revenue, contractual adjustments and net patient service revenue and not be a departure from the standards established by the AICPA when presented in compiliation reports where management has elected to omit substantially all of the disclosures required by GAAP.

Cordially,

John C. Singer

JCS/dh

1511 Judson Rd. P.O. Box 2189 Longview, Texas 75606 (903) 758-3271

Memorandum

To Annette Schumacher

From/Location Martha Garner

Date May 9, 1995

Re Letter from Singer Richardson et al

I cannot tell whether Mr. Singer is asking if he can present gross patient services revenues in the statement of revenues and expenses, or whether he is merely asking if it is permissible to present such information as supplemental disclosures. *Disclosure* of gross revenue and contractual adjustment amounts (excluding any amounts related to charity services) is not proscribed by either the audit guide or the exposure draft. Presenting a gross revenue presentation in the income statement is contrary to FASB Concepts Statement No. 6. I do not think the fact that the information is contained in a compilation report rather than in an audited report is a mitigating factor (although I haven't dealt with requirements pertaining to compilation reports in quite awhile).

Presented below is one possible response to his query. I hope it is useful to you.

Best personal regards ---

*****

The requirement that patient revenues be reported net rather than gross is based on guidance contained in FASB Concepts Statement No. 6, paragraph 79, which defines revenues as follows:

> Revenues represent actual or expected cash inflows (or the equivalent) that have occurred or will eventuate as a result of the entity's ongoing major or central operations.

Because most of the healthcare industry's revenue now is based on negotiated payment arrangements with the government, managed care companies, and other third party payers that pay amounts other than providers' established charges, the cash inflows (and therefore the definition of "revenue") are tied to the negotiated payment rates rather than to the entity's charge structure.

The requirement to adopt a "net revenue" presentation was one of the most significant

changes for the industry when Audits of Providers of Health Care Services was issued in 1990. Some providers that consider a "gross" presentation important with regard to showing Medicare and Medicaid writeoffs have elected to continue to disclose information pertaining to "gross patient service revenue" and "deductions from revenue" in a note to the financial statements or in a supplemental schedule. Alternatively, it may be permissible to disclose the adjustments parenthetically on the face of the statement of revenues and expenses, as follows:

Revenues (net of contractual adjustments of $XX and $XX in 19X4 and 19X3, respectively)	$XXXX	$XXXX

As stated previously, such presentations must exclude all charges and writeoffs pertaining to charity services. Essentially, these types of alternate disclosure would provide users of the financial statements with the same information provided by the statement of revenues and expenses as if it were prepared in the manner described in the letter.

Devereux

May 5, 1995

Annette J. Schumacher
Technical Manager, File H-1-500
Federal Government Division, AICPA
1455 Pennsylvania Avenue, NW
Washington DC 20004-1081

Dear Ms. Schumacher:

The Devereux Foundation, based in Devon, Pennsylvania, is a nationwide provider of high quality health care and education services to children, adolescents, and adults with special needs. We serve individuals with various emotional, behavioral, and mental disorders with the majority of services funded under contracts with state and local governmental agencies. The inpatient/ residential population approximates 2,000, with additional clients receiving outpatient, foster care, and home therapy services.

As Devereux's representative, I would like to comment on the Exposure Draft of the AICPA Accounting and Auditing Guide "Health Care Organizations". Specifically, I wish to address accounting for donor-restricted contributions for long lived assets. While I recognize that consistent practice in the health care industry has been to account for contributions restricted for capital as an addition to the restricted fund balance when received and as a transfer to the general fund when expended, I do not believe this approach properly matches revenue and expense. Under current accounting, the following inconsistences result:

1) The general (unrestricted) fund balance is increased by the full amount of the restricted contribution upon expenditure but is decreased by a corresponding amount over the life of the asset. This results in an immediate overstatement of net assets that is gradually corrected over an extended future period.

2) Operating results are distorted over the useful lives of the related assets since depreciation is recorded with no corresponding recognition of contribution income. Assuming that an entire renovation project is financed by donor-restricted contributions, an operating manager responsible for his/her profitability must include in operating results depreciation of assets that the organization did not have to finance. Thus, the current accounting treatment provides a disincentive for these same managers to fundraise for program expansion.

Depreciation has generally been defined as "the method of allocating the cost of a tangible capital asset... over the estimated useful life of the asset in a systematic and rational manner." In the case of an asset acquired using donor-restricted contributions, the cost of the asset to the organization is $0. In my opinion, there should be no systematic and rationally determined expense charge over the life of an asset that had no original cost to the organization.

For a considerable period of time, I have tried to explain the present accounting treatment to nonfinancial management, who have been unable to rationalize this treatment given the observations outlined above. This has been particularly relevant to Devereux since we are in the latter stages of a $35 million capital

campaign. Many financial statement users are contributors to the organization. They also have difficulty understanding why the operating results are charged with this expense when completion of the capital project was dependent upon their support. Considering the importance of the operating income measure to our organization (as it is to other organizations as well), I believe that the new Health Care Organizations Guide should not perpetuate the current accounting treatment.

There are two methods that could be used to correct these inconsistencies:

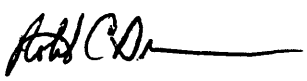
1) Rather than increase the book value of assets and record a fund balance transfer when the donor contribution is expended for a capital asset, the asset cost could be reported net of the donor financed portion. In this manner, the asset would be reported at its actual cost to the organization. If desired, additional disclosures regarding assets acquired could be provided in the footnotes or parenthetically in the balance sheet.

2) Restricted contributions used to finance long lived assets could be recorded as deferred revenue and not added to net assets. Over the related assets' lives, these contributions would be amortized to revenue to offset depreciation expense. In this manner, the concept of depreciation as recognition of the "wear and tear" on assets used in the revenue cycle is maintained but operating results are not adversely impacted. My understanding is that this approach is similar to the one that has consistently been used by Health and Welfare Organizations. It could also be applied to the health care industry.

I respectfully request that the AICPA Health Care Committee reconsider its approach to this complex area. Should you agree that the operating measure should reflect what I believe to be a better matching of revenue and expense and a more appropriate presentation of the costs of using a donated asset, the questions of transition and retroactive application must be addressed. Because many organizations have bond covenants that establish minimum net worth requirements and because determining the cumulative effect presumes availability of records for an extended historical period, any change should be applied prospectively.

Please feel free to contact me at (610) 964-3084 with any followup questions. Thank you for your consideration of my comments.

Very truly yours,



Robert C. Dunne, CPA
Controller

cc: Mr. Robert Kreider, Senior Vice President & Chief Financial Officer
Mr. Emmanuel Lauria, Partner - Ernst & Young

RCD/abs
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MEDICAL CENTER

May 24, 1995

Ms. Annette J. Schumacher
Technical Manager
File H-1-500
Federal Government Division
American Institute of Certified Public Accountants
1455 Pennsylvania Avenue, NW
Washington, DC 20004-1081

RE: AICPA Audit and Accounting Guide, Health Care Organizations (ED)

Dear Ms. Schumacher:

I have read the above mentioned exposure draft and have the following comments:

1. In general, the changes do not improve the usefulness of a health care organization's financial statements or make them more meaningful to external users. In addition, we do not agree with the AICPA Health Care Committee's position that removes the flexibility provided all other organizations adopting FAS Nos. 116 and 117 in the implementation of these statements. Finally, since not-for-profit health care entities, particularly acute care hospitals, compete with for-profit publicly held entities, removing the non-operating section of the statement of activities removes comparability of operating indicators.

2. Although the comment period for the provisions included in FAS No. 117 relative to the treatment of investments has past, we would like to voice our opinion that the boards of not-for-profit hospitals have taken their fiduciary responsibility seriously and have made strides to grow and maintain the corpus of the endowment funds.

   I find the provisions of FAS No. 117 (which require realized gains to be added to unrestricted net assets and not permanently restricted net assets) to be in conflict with a board's fiduciary responsibility. For many years, boards have established spending limits and reinvested amounts in excess of spending limits as corpus of the endowment fund. Reporting realized gains as part of unrestricted net assets is contrary to the concept of maintaining the corpus of the endowment funds and could have a negative impact in future fund raising.

ONE KING PLACE, POST OFFICE BOX 1009, MERIDEN, CONNECTICUT 06450-1009

TELEPHONE: (203) 238-8200

I recommend that the Guide allow for classification of investment activity, including endowment fund related, based on the good-faith determinations made by an institution's governing board, and with appropriate financial statement disclosure of board policy.

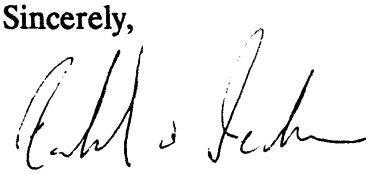
3. I believe that not-for-profit health care organizations should adopt the same GAAP as followed by the for profit sector; for example, follow FAS No. 115. There is no basis for a different position for these two types of organizations.

4. Conservatism continues to be an important concept in the preparation of financial statements. Therefore, I question why the ED requires all unrestricted cash and cash equivalents to be classified as current if the organization has a policy that is consistently followed; for example the funding of depreciation.

I would appreciate consideration of my comments by the AICPA Health Care Committee.

Thank you.

Sincerely,



Ralph W. Becker
Vice President, Finance

RWB:sr

Northern Illinois University
DeKalb, Illinois 60115-2854

John H. Engstrom
KPMG Peat Marwick Professor of Accountancy

Department of Accountancy
(815) 753-6097

June 5, 1995

Ms. Annette J. Schumacher, Technical Manager
File H-1-500, Federal Government Division
American Institute of Certified Public Accountants
1455 Pennsylvania Avenue, NW
Washington, DC 20004-1081

Dear Ms. Schumacher:

This is a response to your ED for Health Care Organizations. For your information, I teach and write in the fields of government and not-for-profit accounting and have been on the AICPA Not-for-Profit Committee in the past. First, I will comment on the two questions in the front of the ED, then I will list some additional comments by page number.

1. Issue 1 on p. v requests comments on the elimination of the FASB option on fixed assets. I wish the FASB had not provided that option and would encourage you to go ahead with your change. However, I would urge you to provide some disclosure regarding the portion of net unrestricted assets that is tied up in capital items. Unfortunately, the FASB allows aggregating the balance sheet in such a way that a reader could be misled into thinking more funds are available than is the case. At the least, I would suggest you encourage more display.

2. Issue 2 on p. v asks whether the valuation allowance related to changes in market value of investments be included in operating income. I would think you would follow the same rules you have for everything else; if income from investments is operating, then this should be too.

3. Paragraph 5.12 on page 29 gives me the impression that conditional promises to give are never recorded as assets until an "asset" is received. I think readers may be a little confused. If a donor indicates, in writing, a conditional pledge, say that $100,000 will be given if matched, is that pledge an asset as defined as the last sentence of the paragraph, or would one wait until cash is received? Paragraph 5.24 seems to indicate only note disclosure at the time of the pledge.

4. Chapter 7 discusses, in 7.4, liabilities other than pension benefits, but nowhere in the chapter do you talk about pension benefits. Since FASB and GASB accounting and disclosure requirements are so different, should they not be mentioned, in terms of sources, etc.?

5. Based on my reading of your 7.9, does this mean that you are giving governmental health care entities the option of reporting in the same manner as not-for-profits in other ways? Can everything be placed in the threefold categories? What is the relationship between this document, which I know has been cleared by GASB, and the GASB ED, "The Use of Not-for-Profit Accounting and Financial Reporting Principles by Governmental Entities?" Paragraph 6 of the GASB document seems to prohibit governmental healthcare entities from using Statement 117, but Paragraph 28 of that document says governmental healthcare entities are not required to change. Does this mean that they can? If not, and paragraph 6 rules, then how can a healthcare entity follow your Paragraph 7.9?

6. In Paragraph 10.2, I have never understood why charity care is not reported as an expense. It would seem to be good public policy to require this disclosure.

7. Paragraph 10.6, at the end suggests that reclassifications may be shown only in the notes. How is that possible?

8. As was the case with my comments on the FASB statements, I am concerned with the flexibility regarding the reporting of functional expenses. In your example statements for the "Sample Not-for-Profit Hospital," you provide only note disclosure of two functions, which is permitted, and you have nothing for fund raising. Your Statement of Operations on page 104 shows one line for "operating expenses," which is hardly good disclosure. How can one line be operating expenses, but "operating income" include many other expenses, which presumably are nonoperating (depreciation, interest, etc.)? Your old audit guide was much better. Your government hospital statement has a good Statement of Functional Expenses in the notes (p. 132) and includes fund raising. My guess is that you are, like the FASB, going to allow anything.

9. In general, I think it is important that you clearly specify what is required by the guide and what is optional. For example, you are apparently requiring a Statement of Operations, with an operating income figure shown. Your Statements of Operations all illustrate expenses by object classification with functional expenses shown in the notes, but it seems that you are not requiring that. My understanding is that the FASB has given you authority to provide narrower requirements than it did in Statement 117, so you should be clear about which is guidance and which is required guidance.

As an instructor of accounting and text writer, I know that the AICPA Examinations Division will use your guide as a source of questions and that educators will use the guide as a basis for teaching. Even though it may not be apparent from the tone of my comments, I feel you have done a good job with the guide and am especially happy that you have provided sample statements. I hope that you can use your processes to aim the FASB and GASB toward the writing of standards that are as common as possible for all healthcare entities. I also hope you can use your processes to develop more detailed guidance than the FASB has in terms of (1) disclosures, (2) disaggregated reporting, and (3) the reduction of flexibility in reporting. Thanks for listening to my comments.

Sincerely,

John H. Engstrom

John H. Engstrom
KPMG Peat Marwick Professor of Accountancy

JHE:mh

BENJAMIN PODGOR
ATTORNEY AND COUNSELLOR AT LAW
32 ABBEY STREET
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(516) 541-6054

Annette J. Schumacher
Technical Manager, File H-1-500
Federal Government Division
American Institute of CPAs
1455 Pennsylvania Avenue,NW
Washington, DC 29994-1081

Re: Proposed Audit and Accounting Guide: Health Care Organisations.

Dear Ms Schumacher:

This letter is in reference to paragraphs: 5.10; 13.5; and 13.6. In December 1992 I presented a formula, which, if followed would make it impossible for an HMO to have a loss*

The formula was published in the CPA Journal. I believe the editor was opposed to HMOs. The title "This HMO Will Not Go Broke." He left out one word. No correction followed.

This formula would provide a way to measure why the Health organization shows a loss. Or better still, use of the formula would make sure there is no loss.

A copy of the article is enclosed. I am prepared to provide additional proof that this formula is workable: by debate; lecture; seminar or in any other form. I have been a member of the Health Care Committees of the New York State Society of CPAs for many years and have been involved in Health Care Field for more than fourteen years.

Sincerely,

Benjamin Podgor

Dated June 12, 1995

Benjamin Podgor

THIS HMO WILL NOT GO BROKE

Benjamin Podgor CPA
(Member of the New York Bar)
32 Abbey Street
Massapequa Park, New York 11762
(516) 541-9292

National Healthcare

The procedure outlined could be the prototype for a National Healthcare System.

1. It calls for private sector operation (non-governmental)
2. Is fair to the patient
3. Is fair to the medical profession
4. Should drive the cost of services down to manageable levels
5. Cuts out unnecessary services
6. Reduces paperwork to almost zero
7. Does not require insurance company participation
8. Will cause doctors to keep patients healthy. They may teach and preach rules of good health.
9. Leaves any temporary miscalculations upon the party most able to carry it.
10. Enables both Medicare and Medicaid to "Buy in" so that National Healthcare is attainable
11. Of course, employers can likewise purchase coverage.

Previous publications of this formula were headed up "This HMO Will Not Go Broke."

One editor published it as "This HMO Will Go Broke." Please judge for yourself. I believe it cannot go broke, because it never distributes more than it receives.

THIS HMO WILL NOT GO BROKE

By Benjamin Podgor, JD, CPA

Health Maintenance Organizations have become very popular in some states as an alternative to health insurance. Typically under HMO statutes, enrolled members are entitled to receive comprehensive health services for an advance or periodic charge. The HMOs do not have to meet the requirements of an insurer under state regulations.

HMOs have frequently ceased operation because of incorrect rate estimates, bad fiscal management, inadequate cash flow, or other financial miscalculations. There is a simple formula to overcome these difficulties, which upon initial examination should be infallible. Risk of loss, if any, will be in the hands of those who can absorb the loss if there is any error or omission.

The formula will be applied to a fictitious HMO, National Healthcare Flagship #1 HMO, Inc. This corporation's stockholders/directors are six physicians or surgeons and two specialists. The stockholders/directors agree that they will assign one unit of service for patient office visits to the physicians/surgeons and two units of service for visits to offices of the specialists. The stockholders/directors have also arranged, by contract, with the local hospital (with which they are affiliated), that the local hospital will accept ten units of service for each inpatient day and one unit of service for emergency or clinic visits.

The National Healthcare Flagship #1 HMO, Inc. has instructed

its controller to use the following procedure:

- Deposit subscriber's annual premiums into a trust account;
- Transfer a full year of administrative, selling, and malpractice expenses into an operating account (The estimate is determined by using a product of the number of subscribers times a unit multiplier);
- Each month, one-twelfth of the funds remaining in the trust account are transferred to a claims payout account;
- At the end of each month, the month's total accumulated units of service are divided into the claims payout account to arrive at a unit value;
- Payments are made to the doctors and hospital using the unit value times each doctor's and hospital accumulated units of service.

Doctors may aim to keep patient office visits to a minimum to keep the unit value at high levels. But they will also want to see patients who need help to avoid malpractice claims. Directors will seek to remove any doctor who is accident prone or creates disproportionate numbers of office visits.

The above is a mere outline of a procedure that should work. To keep it simple, there has been no discussion of DRG's for hospitals or Medicare Resource-Based Relative Value Scale or other physician payout systems.

Also fascinating is the chapter on bailouts, where the author provides the details and reminds us that two of the prime contributors to the S&L debacle were Congress and the regulators.

In discussing congressional perks, the author lists fifteen laws from which Congress has exempted itself, including The Ethics and Government Act of 1978. Did you know that the House once voted against its own pay raise, but only after it becam
effect?

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pensation for large non-national firms was $171,900.

Some other category winners were:

- Miller Cooper & Company, Northbrook Illinois—2,159 charge hours per professional;
- Freidman Eisnestein Raemer Swartz, Chicago—$125 fee per hour; and
- Kenneth Laventhal & Co., Los Angeles—$221,000 revenue per professional.❑

NATIONAL EXECUTIVE SERVICE CORPS WANTS YOU

Your assignment, if you accept it, is to guide the Actors' Fund of America through preparation of its first budget in 109 years. Or if that is not to your liking, to provide North General Hospital with the overall strategy to enable the hospital to return to financial viability.

These are two of many challenging assignments that retired accountants and other executives have accepted as volunteers to help nonprofit organizations through the National Executive Service Corps. Now in its 15th year

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THIS HMO WILL GO BROKE

By Benjamin Podgor, JD, CPA

Health Maintenance Organizations have become very popular in some states as an alternative to health insurance. Typically under HMO statutes, enrolled members are entitled to receive comprehensive health services for an advance or periodic charge. The HMOs do not have to meet the requirements of an insurer under state regulations.

HMOs have frequently ceased operation because of incorrect rate estimates, bad fiscal management, inadequate cash flow, or other financial miscalculations. There is a simple formula to overcome these difficulties, which upon initial examination should be infallible. Risk of loss, if any, will be in the hands of those who can absorb the loss if there is any error or omission.

The formula will be applied to a fictitious HMO, National Healthcare Flagship #1 HMO, Inc. This corporation's

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- Payments are made to the doctors and hospital using the unit value times each doctor's and hospital accumulated units of service.

Doctors may aim to keep patient office visits to a minimum to keep the unit value at high levels. But they will also want to see patients who need help to avoid malpractice claims. Directors will seek to remove any doctor who is accident prone or creates disproportionate numbers of office visits.

The above is a mere outline of a procedure that should work. To keep it

a program required full support of the school board, pilot program supported the change, they added, and such

The police and courts are incapable of dealing with the in an effort to control its inappropriate use by others.

Guest opinion

This is an HMO that won't go broke

by Benjamin Podgor

Our health-care system does not control costs and cover everyone. How can we pay for a system that will cover everyone? Perhaps the CPA can help provide the answer.

Healthcare Maintenance Organizations have frequently ceased operation because of incorrect premium estimates, bad fiscal management, inadequate cash flow or other financial miscalculations. An effective alternate system, such as the one presented here, must overcome these problems.

It appears, upon initial examination, that this formula should be infallible. Risk of loss, if any, will be in the hands of those who can absorb the loss if there is any error or omission.

For purpose of examination, we will call HMO:National Healthcare Flagship #1 HMO, Inc. This corporation's

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Wayne State University
DMC The Detroit
Medical Center

June 18, 1995

Annette J. Schumacher
Technical Manager
File H-1-500
Federal Government Division
American Institute of Certified
Public Accountants
1455 Pennsylvania Avenue, NW
Washington, DC 20004-1081

"Proposed Audit and Accounting
Guide-Health Care Organizations"

Dear Ms. Schumacher:

We are pleased to submit the following comments on the above referenced Proposed Audit and Accounting Guide.

We suggest that the Guide permit continuing use of the classification of nonoperating gains and losses in the Statements of Operations and of Changes in Net Assets. Operating income should include revenues and expenses which result only from activities associated with the provision of health care services because these are the activities which constitute the ongoing major and central operations of health care providers. A category of nonoperating gains and losses is necessary to report peripheral or incidental activities separately from the results of the major activity of providing health care services.

Although income on investments of certain types of funds, such as funds held in trust under bond agreements and professional liability funds, is considered part of operating revenue, income on investments of board-designated and donor-restricted funds is not considered part of the activities of providing health care services and, therefore, should be excluded from the operating indicator. Such investment income is substantial in relation to operating income of The Detroit Medical Center (DMC) and thus must be reported separately to present fairly the results of operations relating to the provision of health care services.

The need to report income on investments of certain funds separately from operating income is made even more crucial by the fair value approach to measurement of investments required by the Proposed Statement of Financial Accounting Standards "Accounting for Certain Investments Held by Not-For-Profit Organizations." Even a relatively small percentage change in the value of investments in securities would be large in relation to the DMC's operating income of any period. Therefore, reporting unrealized gains and losses along with investment income above the operating income caption would result in operating income being determined principally by investment performance with the major activity of providing health care services being an insignificant portion of reported operating income.

The requirement to report expenditures of restricted funds for property and equipment as "net assets released from restrictions" in the statement of operations also supports the need for a separate nonoperating gain classification. In years of major capital expenditures funded by donor-restricted assets, income from operations could be substantially increased by such expenditures.

For the reasons cited above, the operating indicator would be a much more useful measure of operating performance if certain gains and losses could be excluded. The usefulness of the operating indicator would then be further enhanced by the requirements in paragraph 10.14 of the Exposure Draft to describe the nature of the reported measure of operations or the items excluded from operations.

Reporting a category of nonoperating gains and losses separately from operating income is also consistent with FAS 117, which includes the statement that an organization may classify items as operating and nonoperating.

We appreciate the opportunity to present our views on this Proposed Audit and Accounting Guide and would be pleased to discuss them with you or your staff. Please contact us at (313) 745-5166 with any question on this letter.

Sincerely,

Robert L. Melick
Director of Accounting and Financial Reporting

Charlie Johnson
Vice President, Finance/Controller

c: Guy Laprad/Senior Vice-President-Chief Financial Officer
Chief Financial Officers

12666 N.W. 12th Court
Sunrise, Florida 33323
June 27, 1995

AICPA
Attn: Annette J. Schumacher
1455 Pennsylvania Avenue, NW
Washington, DC 20004-1081

Dear Ms. Schumacher,

I am writing in reference to the exposure draft Proposed Audit and Accounting Guide - Health Care Organizations (File H-1-500).

In the preface under the title applicability, it state, "This guide applies to organizations whose principal operations consist of providing or agreeing to provide health care services....". I would like to see the wording of this sentence changed in order for the guide to have wider applicability. I propose that the sentence read, "This guide applies to organizations who have **MATERIAL** operations consisting of providing or agreeing to provide health care services..." I believe that my modified wording would allow the guide to apply to organizations who self insure their health care costs. It is my opinion that disclosure required by the guide would be an improvement over current disclosure requirements. I believe that my proposed modification is consistent with the guide including paragraph 2.34 which makes mention that providers of health care may use outside organizations to perform tasks including the administration of employee benefit plans. This is typical of the many large corporations which use "administrative services only" contracts when administering their health plans.

Paragraph 13.8 - I would like to see a reference to FAS 113-Accounting and Reporting for Reinsurance of Short Duration and Long Duration Contracts as this FAS governs the accounting for stop loss insurance.

I have several comments regarding Chapter 14 - Continuing Care Retirement Communities.

Paragraph 14.22 - A CCRC is required to estimate refunds associated with advance fees. I assume that these refunds will be paid over several years. Thus I propose that this liability be recorded in a manner consistent with discounting, an issue which was placed on the FASB's agenda in October 1988.

Paragraph 14.25 - Deferred revenue should be amortized to income over future periods based on the remaining useful life of the facility. This is reinforced by the sentence "The basis and method of amortization should be consistent with the method for calculating depreciation...". Considering that different organization may use different methods of depreciation and that a facility is to be depreciated over a period not to exceed 40 years,

I question the association of depreciation with the deferral of revenue. After all what happens when the facility is no longer being depreciated? Is the entity allowed to recognize this deferred revenue in the current period?

Paragraph 14.29 - This paragraph provides the formula for determining the entities liability for future services and facilities. Once again I am concerned about the use of depreciation in this calculation.

Exhibit 14.2 - On page 97, the facility is assumed to have a 40 year useful life. I would suggest that you modify this to be consistent with exhibit 14.1 where the building has a 30 year useful life.

Exhibit 14.2 - I do not see where guidance is provided on how to allocate depreciation when the facility has a vacancy. For example, if the monthly depreciation is based on 200 residents, what happens when only 199 residents occupy the facility? Does the full depreciable amount get allocated to the 199 units or does it get allocated to 200 units with the organization assuming responsibility for the vacancy. I believe that there should be a provision for utilization of the facility in the CCRC's obligation to provide future services and facilities.

If any of these comments are unclear, or you wish to discuss them further, please feel free to contact me at the above address or at (305) 846-2528.

Sincerely,

George Tayar

George Tayar

Managed CARE Re
Insurance • HealthCare • Reinsurance

June 28, 1995

Ms. Annette J. Schumacher
Technical Manager, File H-1-500
Federal Government Division
American Institute of Certified Public Accountants
1455 Pennsylvania Avenue, NW
Washington, DC 20004-1081

Re: Exposure Draft - "Proposed Audit and Accounting Guide—Health Care Organizations"

Dear Ms. Schumacher:

I recently requested copy of subject. Following are comments:

Pp. XIII, 11, 12. I believe the more prevalent term is "Independent Practice Associations."

P. 2. SFAS #117 requires that what were formerly statements of revenue and expenses and changes in fund balances be replaced by a "statement of activities." Exposure Draft calls for a "statement of operations." Am I correct in concluding that the Guide will supersede SFAS #117? (I prefer the title used in the Guide.)

Pp. 3, 62, 65. I am pleased to note that when material, revenue derived from capitation arrangements is to be classified as "premium revenue." However, I do not believe that capitation applicable to care that will be provided directly by the entity should be classified as "premium revenue." Such capitation represents the amount applicable, for the period reported on, to health care costs incurred within the entity for covered members. It does not differ fundamentally with Medicare DRG-based payments, which vary depending on case mix intensity. Accordingly, I believe such capitation should be included in the "patient service revenue" classification.

Typically, a significant portion of gross capitation received by a health care organization is for care to be rendered outside the facilities of the entity. Examples would be capitation components for:

- Out-of-Area Services
- Tertiary Services not provided by the entity

1430 East Missouri Ave, Suite 225, Phoenix, Arizona 85014
1-800-289-0957 • (602) 230-2266 • FAX (602) 230-2148

- Other services, if any, not provided by the entity (e.g., durable medical equipment, transportation, etc.)

For the above-described portion of gross capitation, I agree that the appropriate classification, if material, is "premium revenue."

As stated in both the Guide and SFAS #117, revenue and expense items are to be reported gross. Under these circumstances, how would expenses related to premium revenue be classified? (Very often, expenses for out-of-area and tertiary services provided—including IBNR—exceed the capitation related thereto.) I assume that such expenses would be reported as part of functional or natural expense classifications.

Finally, I have a general concern about reporting (including note disclosure) of capitation revenue and expense because it is so competitively sensitive in terms of contract negotiations. Accordingly, I hope that revisions, if any, to the Guide will be cognizant of such sensitivity. This point will be particularly important when the Guide is applied to IPA's, PHO's, etc.

Sincerely,

Robert A. Jordan
Financial Consultant

RAJ:jsv/ameschsa.ltj

P.S. Formerly a member of the AICPA Health Care Committee.

Managed CARE Re
Insurance • HealthCare • Reinsurance

July 19, 1995

Ms. Annette J. Schumacher
Technical Manager, File H-1-500
Federal Government Division
American Institute of Certified Public Accountants
1455 Pennsylvania Avenue, NW
Washington, DC 20004-1081

RE: Exposure Draft - "Proposed Audit & Accounting Guide - Health Care Organizations"

Dear Ms. Schumacher:

I recently wrote regarding some capitation issues related to subject. After further review, I have concerns about the Sample Not-for-Profit Health Maintenance Organization Statements of Operations on page 161. I believe that the Insurance Committee should be consulted regarding the format of the statements. Because an HMO is regulated as an insurance industry entity, this is to suggest that "Benefits and expenses" should replace "Expenses." Accordingly, benefits, claims, commissions and general administrative expenses should be reported together with interest expense in arriving at "Total expenses" together with appropriate note disclosures. With respect to note disclosures, adoption of the above reporting change would preclude providing "program" expenses, which I believe to be inappropriate from a competitive sensitivity point of view.

Sincerely,

Robert A. Jordan, CPA
Financial Consultant

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2266 E. Cape Cod Drive
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July 17, 1995

Annette J. Schumacher
Technical Manager
File H-1-500
Federal Government Division
American Institute of Certified Public Accountants
1455 Pennsylvania Avenue, NW
Washington, DC 20004-1081

Dear Annette

It is a pleasure to provide comments on the "Proposed Audit and Accounting Guide: Health Care Organizations."

Key areas for improvement or change

Classes of organizations

SFAC No. 4 says a not-for-profit organization has an "absence of defined ownership interests that can be sold ..." (Paragraph 6.c.)[1]. The healthcare guide says simply that the distinguishing characteristic of a not-for-profit, business-oriented organization is that it has "no ownership interest..." (1.2b). This very restrictive definition conflicts with many provisions of Chapter 11 which refers to transfers of ownership or ownership interest (paragraphs 11.19 - 11.24, particularly).

The definition of an investor-owned healthcare enterprise says it may be owned by "investors or others." "Others" could include catholic orders, other church organizations, communities, authorities, and so on.

Paragraph 1.3, quotes SFAC No. 4, paragraph 8 which says "the objectives of FASB Concepts Statement No. 1 may be more appropriate ..." for organizations that are self sustaining from fees. Footnote 3 of SFAC No. 4 makes it clear that the FASB concept of not-for-profit focusses on organizations that are heavily dependent on contributions, the type provider defined in

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[1] Each new document seems to introduce a new definition of not-for-profit organizations. The not-for-profit guide refers to "pecuniary return" (1.01(a)) while SFAC No. 4 refers to "repayment or economic benefit." Paragraph 1.01(c) of the not-for-profit guide refers to an "absence of ownership interests..." but SFAC No. 4 adds that there is an absence of ownership interests "that can be sold..." These are subtle but important difference indicating the difficulty in drawing a bright line between types of entities.

paragraph 1.2d as being outside the scope of the healthcare guide.

Paragraph 1.4 endorses consistency, noting that some entities have unique transactions but such transactions do not define a separate classification of entity.

These conflicting concepts could be resolved in the following ways:

1. 1.2 b. should conform more closely to SFAC No. 4 in its reference to ownership.

2. The sub heads on page 59 should be changed to "Reporting ownership interest" and "Reporting donor restrictions." Some modification of content is needed to match these subheads.

3. The illustrative financial statements should be relabeled:
   Hospital, not-for-profit
   Hospital, governmental
   Nursing home, investor-owned
   Continuing... (etc.)
   This labeling makes the type of healthcare service primary and the ownership secondary. There should be a statement saying that each illustrative statement must be adapted to reflect the ownership, mission, and program of each provider. The labeling should avoid the impression that hospitals are probably not-for-profit or that nursing homes are probably investor-owned. Neither assumption is true.

Nomenclature and format

The "Proposed Audit and Accounting Guide: Not-for-Profit Organizations" includes some helpful language concerning nomenclature and format that should be incorporated in the healthcare guide. Footnote 1 on page 18 of the not-for-profit guide specifies that terms such as "Statement of Financial Position...serve as possible titles... Other appropriately descriptive titles may also be used ... (such as) balance sheet..." Similarly, paragraph 3.08 and footnote 1 on page 105 of the not-for-profit guide say the term "equity" is an acceptable synonym for "net assets."[2] Footnote 2 on page 105 also mentions flexibility in terminology. These provisions are desirable and should be added to the healthcare guide. Such provisions allow healthcare providers to follow a business style

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[2] Acceptability of the term "equity" for not-for-profit organizations is also noted in SFAS No. 118, paragraph 18.

in their financial reports if they choose, thus communicating most clearly with business oriented board members, creditors, community leaders accustomed to business operations, and others. Such business oriented statements help providers portray their business-like operations.

It is desirable that the healthcare guide endorses a statement of operations separate from a statement of changes in equity. In accordance with Paragraph 18 of SFAS No. 117, the healthcare guide says the statement of operations must include "all changes" in unrestricted equity (1.5). However, there are several problems in the way terms related to the statement of operations are defined and in the format suggested for the statement:

1. The difference between a) revenues and expenses and b) gains and losses is never clearly stated. Paragraph 10.1 says this is discussed in paragraphs 10.2 and 10.10 but those paragraphs are irrelevant to this issue. Discussion of this issue must begin with reference to the distinction made in SFAC No. 6, which says revenues (paragraph 79) and expenses (paragraph 81) relate to the entities "ongoing major or central" activities and gains (paragraph 82) and losses (paragraph 83) relate to "peripheral or incidental transactions." This distinction is made clearly in the not-for-profit guide in paragraphs 12.02 and 12.03.

2. There is inadequate recognition that healthcare providers may be engaged in more than the provision of health services. An organization might decide, based on its mission, that healthcare services is not its only major segment warranting segregated reporting in its statement of operations. For example, a provider might choose to report the revenues and expenses of its educational programs separate from its healthcare services. Reporting on multiple activity segments is consistent with and should be done in accordance with GAAP for segment reporting--another application of business accounting guidelines to all types of healthcare providers. Segment reporting is mentioned in 10.17 but with no discussion of how it affects healthcare providers.

   The healthcare guide almost suggests that a provider differentiate between its revenues and expenses of healthcare services (the activities discussed in paragraph 10.3) and other activities (discussed in paragraph 10.5). This differentiation should be advocated more specifically. With this differentiation, the statement of operations would distinguish between 1) revenues and expenses of healthcare services (and, if appropriate, other segments of operations)

and 2) revenues, expenses, gains, and losses, from other activities.

The illustrative hospital statement of operations (page 104) encourages readers to add "other revenues" and gains to program revenues when comparison is made to program expenses. Clear reporting of the financial results of providing healthcare services (or other segments of operations) will avoid this confusion.

Paragraph 12.05 of the not-for-profit guide and its related footnote 3 describe one method of reporting revenues, expenses, and margin on individual activities. This is one possible way for healthcare providers to also provide information on segments of operations and would be a desirable addition to the healthcare guide.

3. The healthcare guide does not describe or illustrate the difference between operating and nonoperating clearly. This results from the inadequate differentiation between revenues and gains and between expenses and losses. Paragraph 23 of SFAS No. 117 discusses intermediate measures of operations, noting that "an organization may classify items as operating and nonoperating..." and acknowledging that such terms as "operating profit" or "results of operations" may be used. The difference between operating and nonoperating needs to be discussed and illustrated.

Functional reporting

For healthcare providers, differentiating between healthcare services (or multiple segments) and other operations is far superior to FASB's required functional reporting. The healthcare guide properly relegates the required functional reporting of expenses to a minor place (paragraph 10.18). I agree with the implied preference that functional reporting be dealt with in the notes rather than being the classification method used on the face of the statement of operations. This preference should be expressed more clearly.

Some additional information is needed concerning functional reporting:

1. The differentiation between program and administrative expenses required by FASB encourages readers to relate program revenues to program expenses excluding the portion of administrative expense that is essential to produce the program revenue. The minimum functional expense reporting advocated by the healthcare guide reduces the possibility of misleading interpretations. Reporting healthcare services

revenues and expenses and the resultant profit or loss, as advocated previously in this letter, will make the financial results of primary activities perfectly clear and avoid misinterpretations.

2. Paragraph 10.18 must be expanded to a) define the two functional categories that must be reported (program services and supporting activities) as specified in SFAS No. 117, paragraphs 26 - 28, b) specify that the cost of fund raising activities must also be reported as a function, if material, and c) mention that some overhead is allocated to program services (such as space related expenses) but other overhead must not be allocated (such as general and financial management). The final sentence of paragraph 10.18 is incorrect in its reference to "full cost allocation" because the function "management and general" must be reported separately; it must not be allocated.

   There are several sections of the not-for-profit guide that should be added to the healthcare guide:
   - -- 13.04 says expenses but not losses must be classified by function.
   - -- Footnote 1 on page 111 says allocation of costs that benefit more than one function is necessary
   - -- 13.31 says that supervision of program services is part of the program service function, not part of management and general which only includes oversight of the entire organization. Thus, the director of nursing is part of the program service function, not the management and general function.
   - -- 13.35 says it is preferable to identify expenses directly with functions.
   - -- 13.37 makes it clear that space costs are not a separate function.
   - -- 13.37 discusses assigning interest expense to functions.

   Some discussion is needed of the relationship between a) the limited and selective functional classification of cost required by FASB and b) the need for full cost allocation to meet the needs of management and regulatory and rate setting requirements.

In accordance with the above thoughts, my view on issue 2 is that changes in the valuation allowance of investments should be included in the statement of operations below profit or loss from program services with other revenues, expenses, gains, and losses.

Contributions

The healthcare guide should simply refer to chapter 5 of the not-for-profit guide concerning contributions because the subject is too complex and the application too tangential to healthcare entities to devote the content necessary to fully cover the issue in the healthcare guide.

If the healthcare guide retains discussion of contributions, it needs to be checked for consistency with the not-for-profit guide and the following changes are needed:

1. The discussion of agency funds in paragraph 3.2 does not deal adequately with this aspect of contributions. The not-for-profit guide deals with this very complex aspect of contributions in paragraphs 5.02, 5.04 - 5.08 and table 5.1.

2. Paragraph 5.13 refers to "restricted support." This term is not in the glossary or illustrative financial statements. This sentence might be more clear if it referred to an addition to donor restricted equity.

3. The discussion of pledges due in future periods (5.13) is much too complex and should be rewritten.

4. More definitive rules are needed concerning "present value" (5.14) such as is provided in the not-for-profit guide in paragraph 5.54.

5. While SFAS No. 116 does not seem to require it, disclosure of the present value adjustment to pledges receivable in future periods seems appropriate and should be suggested, at least as an option (5.23).

6. Paragraph 9.5 implies, in the sentence that runs from page 59 to 60, that a "term endowment" includes both a time and purpose restriction. "Term endowment" is a synonym for time restriction and does not include purpose restrictions. The definition of "endowment fund" in the glossary describes "term endowment" correctly.

7. Paragraph 10.4 refers to a "relatively small amount of contributions..." This would be less denigrating and more accurate if it said a "relatively small percentage of total revenues from contributions..."

8. Paragraph 10.7 says "Donations received with no restrictions attached are reported as unrestricted support in the statement of activities." The term "support" needs to be defined and the term "statement of operations" should be used.

9. Paragraph 10.7 refers to "temporarily restricted support." This term is not defined and is not used in the illustrative financial statements. It would seem better to say that "amounts received from donors with temporary restrictions are an increase in donor temporarily-restricted equity." Reference to paragraphs 1.15 - 1.17 would be helpful.

10. Donated long-lived assets should be recorded as contributions when the assets are placed in service. This is probably when the contributed asset is received, as specified in paragraph 10.8, but there can be a delay between receipt and placing the asset in service and that possibility should be recognized. This change would conform paragraphs 10.8 and 10.9. Paragraphs 10.8 and 10.9 should be merged, excluding the second half of paragraph 10.9 which should be a separate paragraph.

    I agree with the proposal as stated in issue 1; healthcare providers should not have the option, permitted by FASB, of reclassifying the value of a donor's gift of long-lived assets from donor temporarily-restricted equity to unrestricted equity over the life of the long-lived asset.

11. Paragraph 10.10 needs to be revised to conform to SFAS No. 116, paragraph 9. As written, this paragraph says that contributed services do not need to be recorded because it is difficult to determine a monetary value. This sentence might say, "Because it is difficult to place a monetary value on such services, the value has often not been recorded" followed by a sentence such as, "However, even though contributed services are sometimes difficult to measure, they should be recorded if... (paraphrase or quote SFAS No. 116, paragraph 9)."

There should be more cross referencing between the various places where contributions, especially donor restricted contributions, are discussed. These topics are discussed in 1.12 - 1.17, 5.11 - 5.15, 9.4 - 9.6, and 10.7 - 10.11.

Uncompensated services

Paragraph 7.7 should be expended to make it clear that provision of uncompensated service is not the sole criteria for tax-exemption. Sentences such as the following would be a good addition after sentence 2:

> Most healthcare providers, regardless of ownership or tax status, provide uncompensated services. The provision of uncompensated service is not synonymous with the term "charitable" but is one of many factors considered in the

IRS evaluation of a healthcare provider's qualification for tax-exemption. There is not necessarily a correlation between the amount of uncompensated services and the value of tax exemption.

Paragraph 10.2 improperly says that services are provided "free of charge." HFMA's Principles & Practices Board Statement No. 15, paragraph 7.2 more accurately says "Only the portion of an account that meets the organization's charity service criteria is recognized as charity." Other sentences on this subject from P&P Board Statement No. 15 that are preferable to the healthcare guide include paragraph 1.1, "Charity service is provided to a patient with demonstrated inability to pay..." and paragraph 2.1 "Each ... provider (establishes its own) criteria for charity service consistent with the organization's mission and financial ability."

Effective date

The proposed effective date is for fiscal years beginning after June 15, 1995 (with a delay to December 15, 1995 for small organizations). There is no basis for the June 15 date and it is prior to the end of the comment period for the proposed healthcare guide. SFAS No. 116 and No. 117 are effective for fiscal years starting after December 15, 1994 (with a delay to December 15, 1995 for small organizations). There was no better guidance available on June 15, 1995 than there was on December 15, 1994, so an effective date before a new healthcare guide is issued makes no sense. There should be a commitment to complete the healthcare guide by December 15, 1995 and make it effective on that date. Large providers will be operating without specific guidance for a year but the June 15 date does not correct that problem and simply adds confusion about when action must be taken.

Summary of above suggestions

Classes of organizations

Clearly define the critical criteria for differentiating between classes of organizations and minimize the differences between classes.

Nomenclature and format

Make it very clear that business nomenclature is permissible and use such nomenclature whenever possible.

Clearly define revenues and expenses as differentiated from gains and losses.

Allow for reporting on segments of operations and for differentiating between operating and nonoperating.

Functional reporting

Express a clear preference for using the natural expense classification on the face of the statement of operations.

Define required functions more clearly and identify considerations, such as cost allocation, that are required in connection with functional reporting.

Make clear the differences between functional reporting and full cost accounting.

Contributions

Remove specific guidance concerning contributions from the healthcare guide and refer to the guidance on this subject provided by the not-for-profit guide.

Uncompensated services

Describe uncompensated services in relation to the provider's criteria; these are not "free-services."

Effective date

Make December 15, 1995 the effective date of the healthcare guide.

Summary of Responses to Specific Issues for Comment

1. Donated long-lived assets should be reclassified from donor temporarily-restricted equity to unrestricted equity when the asset is placed in service. This should be the only acceptable procedure for healthcare providers.

2. Changes in the valuation allowance of investments should be included in the statement of operations below profit or loss from program services.

Minor fine tuning

1. Reference to SFAS No. 116 and No. 117 in the Preface of the not-for-profit guide is very good. That guide says "... those Statements should be read in conjunction with the Guide..." Similar references from the healthcare guide to SFAS No. 116 and No. 117 and to the not-for-profit guide would be appropriate.

2. The cross references from one section of the healthcare guide to other sections is helpful. Issues are not always discussed where a reader might expect or detailed discussion in one section may augment a brief mention in another section. In the absence of an index, another way to help readers find the subjects they seek would be to include references in the glossary to the section of the guide where the term is used. One subject that is scattered through the document with poor cross referencing is contributions.

3. The glossary probably should be expended to include terms such as equity, net assets, pledge, promise to give, tax exemption, and term endowment.

4. Paragraph 1.18 should refer to "financial risk," not "audit risk" (the first time "risk" is mentioned in this paragraph, the term "financial risk" is used). An alternative would be to use "inherent risk", the language of the section starting with paragraph 2.7.

5. The sentence in paragraph 3.2 that "Agency funds are included in unrestricted net assets" is incorrect. Agency funds have no revenue or expense effect and therefore are not included in any equity accounts.

6. In the introduction to chapter 4, it would be helpful if SFAS No. 115 was briefly described and contrasted to the provisions of the healthcare guide.

7. Chapter 4 does not describe why investments would be classified as long-term but the not-for-profit hospital illustration uses this caption. Paragraph 10.9 says assets that are donor restricted for long-term purposes are not current assets (10.9), however, this provision should be in a separate paragraph, not so restrictively linked to the contribution of long-lived assets.

   There seems to be confusion in the field concerning the classification of investments as current or long-term. This issue should be discussed more fully. Material in the not-for-profit guide paragraphs 3.03 and 3.20 deal with this subject clearly.

8. Paragraph 7.15 should say "The affiliation of a healthcare provider with a financing authority does not automatically classify the provider as a governmental entity."

9. References to "discounting" in paragraph 8.12 should be changed to refer to "present value" similar to paragraph 5.14.

10. The portion of paragraph 10.8 concerning long-lived assets received with a donor restriction needs to be clarified. If reclassification of donated long-lived assets is required when the asset is placed in service, including such as asset in donor temporarily-restricted equity is necessary only if the donor specifies how long the asset is to be used. An example, such as in paragraph 9.08 of the not-for-profit guide, would be helpful.

11. The term "investor-owned" is usually used (for example, paragraph 1.2a) but chapter 11 uses the term "for-profit." Neither term is in the glossary, it is not completely clear that the terms are synonyms, and consistent language will help reader understanding.

12. The illustrative financial statements should be consistent in all respects except for differences that are meaningful. For example, the government hospital illustration uses the term "supplies and other current assets" while the not-for-profit hospital illustration refers simply to "other current assets." There is no substantive reason for this difference and such differences should be eliminated.

13. On page 117, it seem likely that the total in the table with note 14 should be $98,055 to agree with total expenses on page 104. Also, this note should provide information for two years like all other notes. Finally, this note should use the caption "management and general" to conform to SFAS No. 117.

14. Check lists in the not-for-profit guide that are better than similar material in the healthcare guide are:

    -- disclosures about investments (8.22 - 8.25 of the not-for-profit guide, 4.8 of the healthcare guide).

    -- disclosures about property and equipment (9.10 - 9.12 of the not-for-profit guide, 6.7 of the healthcare guide.

I will be happy to discuss these comments and also hope things are going well for you.

Sincerely

R. R. Kovener, FHFMA
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THE FRONTIER GROUP

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July 31, 1995

Ms. Annette J. Schumacher
Technical Manager
File H-1-500
Federal Government Division AICPA
1455 Pennsylvania Avenue, NW
Washington, DC 20004-1081

Re: Exposure Draft
Proposed Audit and Accounting Guide
Health Care Organizations

Dear Ms. Schumacher:

The Long Term Care Committee of the Massachusetts Society of Certified Public Accountants has reviewed and discussed the above noted exposure draft and is in substantial agreement with the general guidelines expressed in it, and has no further comments. This does not necessarily represent the positions taken by the organizations that employ the individual members of the Committee.

The Committee appreciates the opportunity to participate in your due process procedures and have our views considered.

Very Truly Yours,

John P. Burke, Chairman
Long Term Care Committee of the MSCPA

cc: Thomas J. Vocatura

A PROFESSIONAL CORPORATION

Richard J. Serluco & Co.

CERTIFIED PUBLIC ACCOUNTANTS

July 31, 1995

Annette J. Schumacher
Technical Manager
File H-1-500
Federal Government Division AICPA
1455 Pennsylvania Avenue N. W.
Washington, D.C. 20004-1081

Dear Ms. Schumacher:

Our firm provides professional accounting and auditing services to a number of health care providers. Accordingly, we are pleased to submit our comments to the AICPA's Exposure Draft entitled "Proposed Audit and Accounting Guide - Health Care Organizations". We have included our comments on the following pages and would be pleased to provide the Committee with any additional information or clarification relative to our comments. Should you require such information, please do not hesitate to contact Richard J. Serluco at (908)946-2211.

Very truly yours,

Richard J. Serluco & Co.
(A Professional Corporation)

COMMENTS TO AICPA'S EXPOSURE DRAFT
PROPOSED AUDIT AND ACCOUNTING GUIDE - HEALTH CARE ORGANIZATIONS

In response to the Committee's request, we are pleased to submit our comments to issues one (1) and two (2) and also wish to make specific comments relative to other sections of the Guide.

Issue 1. Expirations of Donor-Imposed Restrictions on Long-Level Assets

We concur with the Committee's conclusion that the expiration of donor imposed restrictions on long-lived assets should be recognized when the asset is placed in service as contrasted to allowing an option to recognize it over the life of the asset. In our view, the donor restrictions are satisfied when the long-lived assets are purchased and placed into service as contrasted to when they are utilized. By eliminating the option to Providers, it would also eliminate different amounts being recognized as revenues for similar contributed capital assets. Also, in cases where the long-lived assets placed in service are non-depreciable i.e. land, the concept of proration based on usage is irrelevant and could result in different accounting for such long-lived assets. Finally, inconsistency in Provider reporting for contributed capital assets could also result assuming the following example. If an unconditional contribution was received directly by the Provider and designated by the Board for the purchase of equipment, i.e. an x-ray machine, the contribution would be recognized as revenue at the date the contribution was received and not over the life of the depreciable asset. On the otherhand, if an x-ray machine was donated and the Provider recognized the contribution over the useful life of the asset, for example, 10 years, the two Providers would reflect different revenue amounts for a similar transaction in the year of the contribution.

Issue 2. Accounting for Investments

We do not believe that investment valuation allowances, recognized investment gains and losses or investment portfolio income items should be recognized above the operating income line in the Statement of Operations for a health care provider. It has been our experience that such sources of revenues and investing activities are peripheral to the provision of health care services and as such should not be included when measuring operating performance. Also, by including such items above the line, it may distort a trend analysis of future earnings should the investments, which generate the income, be used in the future as part of the Provider's equity contribution toward a construction program.

The following comments relate to other sections of the Guide:

Chapter 1.

The Proposed Guide continues to use the term **Balance Sheets** when referring to health care provider financial statements as contrasted to a Statement of Financial Position as required by FASB #117. We understand that one of the objectives of FASB #117 was to achieve consistent reporting by all not-for-profit Organizations. The Proposed Guide would not accomplish this objective. We believe the titles of the illustrative financial statements in the Guide and FASB #117 should be consistent. Accordingly, we suggest the narrative and applicable illustrative statements in the Proposed Guide use as a heading a Statement of Financial Position rather than a Balance Sheet. Such a presentation would also be consistent with the conclusions reached by the AICPA Not-for-Profit Organizations Committee and incorporated into the Proposed Not-for-Profit Guide covering Voluntary Health and Welfare Organizations, Colleges and Universities and Other Non-profit Entities.

Paragraph 1.9 of the Guide indicates that gross revenues should not include charity care. From a conceptual point of view, we agree with this conclusion. However, from a factual point of view, we are aware that many organizations are still including charity care as gross revenues and then reducing such amount by charity allowances to arrive at net patient service revenue. Accordingly, the Committee may want to reexamine its conclusion in this area.

Chapter 2.

Paragraph 2.26 makes reference to Individual Practice Associations, however, the Guide does not provide illustrative financial statements on such organizations. If the Guide intends to cover such organizations, then more specific details should be provided. On the otherhand, if IPAs and other group practices are being excluded from the Guide, perhaps paragraph 2.26 similarly should be excluded.

Chapter 3.

Paragraph 3.4 of the Guide indicates there are no unique auditing considerations in regard to cash and cash equivalents. However, it may be appropriate to include in the Guide the auditing considerations which should be considered by the Auditor when auditing cash and cash equivalents.

Chapter 4.

Paragraph 4.3 indicates that **"some noteworthy features related to accounting for investments for not-for-profit health care organizations are (a) accounting by net asset category to comply with and account for donor restrictions on investment practices and (b) valuation of marketable equity securities."** We question whether any donor restrictions would impact the accounting for investments or other assets. A donor may indicate that a particular marketable security may not be sold, however, the accounting of that asset at the present time would be recorded at the fair value of the asset, if donated, or cost, if purchased, and still be determined and accounted for by the lower of cost or market principle. Accordingly, we

request the Committee provide additional clarification or guidance relative to this paragraph.

Paragraph 4.5 seems to imply that separate accountability must be maintained over assets in order to measure them against any donor restrictions. Again, in this case, we are not sure that there is any accounting requirement to separately account for the assets. Rather, the accounting requirement we believe is relative to the accounting for the restricted equity. This paragraph appears to be the only place in the Guide where there is an attempt to track the specific restricted equity with the related asset. We are not sure why such a narrative has been included and perhaps the Committee could provide more guidance or clarification in this area.

Chapter 5.

Paragraph 5.23 discusses **Promises to Give in Future Periods (Pledges)** and basically focuses on disclosures. We believe that some additional information should be included in the Guide related to accounting for unconditional pledges. Such items as using appropriate discount rates or reference to APB #21, in order to arrive at the present value of pledges to be collected in subsequent periods, and the methodology to be utilized to develop allowances for uncollectible pledges should be addressed. Similarly, in the Auditing Considerations of this chapter, we believe that specific criteria should be set forth for pledge receivables as these receivables are unique and different from other types of receivables.

Chapter 6.

In the Auditing Considerations section, we believe there should be some specific reference made to leased property and the auditing and accounting related to such items.

Chapter 7.

Paragraph 7.1 includes a reference to paragraph 1.14. We could not connect this reference based on the content of this paragraph.

In paragraph 7.18, there is a discussion of **advanced refunding**. The Committee may want to consider also including a brief discussion of the reimbursement implications, particularly Medicare and Medicaid, associated with a loss of advanced refundings.

Chapter 9.

In the **rights and obligations** section of the Auditing Considerations, we believe that one of the auditing procedures should be to review the underlying documentation supporting the classification of certain contributions. We feel there is also a need to clarify and discuss any reclassification of temporarily or permanently restricted equity balances to unrestricted equity that may be required as a result of implementing FASB #117. Specifically, FASB #117 indicates that entities who had increased temporarily restricted or permanently restricted funds by capital gain amounts, where such increases were not required by State law or donor restrictions, may reclassify those

amounts to unrestricted equity. In this regard, we refer the Committee to paragraphs 22, 129 and 130 of FASB #117 which discusses this matter. Since Providers may perform the necessary analysis to support such reclassifications of equity balances, we believe the Committee should address this issue.

Chapter 10.

Relative to paragraph 10.5, we do not believe that other operating revenue should include interest and dividend income or changes in market value of securities. We believe these sources of income and activities are peripheral to the operations of health care providers and should be reported as non-operating income. Also, we believe the comparability of results of operations of health care providers may be distorted simply because of the socio-economics of the area in which the Provider is located. That is, a Provider with a significant amount of endowments or contributions could show significantly more operating income merely based on its socio-economic area. These factors have nothing to do with the management or operation of the Provider, but, rather are dictated by factors extraneous to operational matters. Accordingly, we believe that the Committee must give serious consideration to incorporating a non-operating income classification in the Statement of Operations as was permitted in the prior audit guide.

With respect to paragraph 10.10 dealing with donated services, we believe this section must be expanded upon by the Committee to provide additional and specific guidance. FASB #116 provides certain illustrations when donated services are to be recognized in the financial statements. The FASB emphasis appears to be on whether the individual providing the services is qualified to provide such services i.e. licensed. However, we believe, if comparability of financial statements among health care providers is a key component, some consideration or discussion must be given by the Committee relative to those services that may be provided by volunteers who may not possess any special skill or licensure, but, if such services were not provided by volunteers, they would have to be purchased. Certain health care providers specifically due to the socio-economics of their catchment area enjoy the benefits of many volunteer hours of service. Some hospitals, for example, utilized volunteers as escort personnel, reception desk personnel and service personnel in hospitality shops, etc. Inner city hospitals, on the otherhand, often do not have volunteers providing these services and are required to pay for such services. Although the above services and functions may not require special technical skills or licensure, the services would have to be purchased if not supplied by volunteers. Again, if comparability of Provider financial statements is an objective of the Committee, some discussion or recognition of these types of contributed services must be considered in the Guide.

Paragraph 10.15 includes the following sentence, **"In addition, with regard to contractual adjustments and third-party settlements, identification and explanation of estimated amounts that are payable or receivable by the entity are disclosed"** (emphasis added). This requirement, as it relates to the items underlined above, appears to go beyond disclosure requirements of generally accepted accounting principles. We are unsure of the need for such additional disclosures.

Paragraph 10.17 indicates that **"not-for-profit organizations that report using a natural classification of expenses are required to disclose expenses by functional classifications."** Also, the closing sentence of paragraph 10.18, indicates **"Functional allocations should be based on full cost allocations."** In reviewing the illustrative financial statements for a hospital, such functional classification of expenses did not appear to be adequate. It would appear the description and types of functional expenses of hospitals should be expanded rather than using a broad definition of "health care services" as presented in the Guide. For example, in-patient, out-patient services, research, etc. could be utilized or general services, nursery care services and ancillary services could be utilized. In the other Provider illustrative financial statements presented in the Guide, there were several examples where natural classification of expenses have been reflected and allocated to different programs. It would appear that a similar presentation should be made for hospitals. Accordingly, we suggest the Committee expand this section and also include an expanded discussion of full cost allocation methodologies.

Chapter 11.

Paragraph 11.12 indicates the following **"If the reporting entity controls a separate not-for-profit entity through a form other than majority ownership (paragraph 11.10) or voting interests (paragraph 11.11), has an economic interest in that other entity, and consolidated financial statements are not presented, the notes to the financial statements should include the following disclosure:"** We question, with regard to this sentence, whether footnote disclosure is adequate. We believe in some circumstances, an exception to the financial statements should be taken i.e. adverse or disclaim an opinion. Accordingly, the Committee may want to consider expanding this paragraph to cover such areas.

In paragraph 11.20, there is reference to transfers by a foundation to a hospital. Although we agree with the conclusion reached as set forth in the Guide, we wish to point out that there may be some cases where hospitals initially transferred equity to a foundation and treated such transfers as equity transfers. To the extent that the original equity is now subsequently being transferred back to the hospital by the foundation, it may not be appropriate for the hospital to record such transfers as contribution income, but, rather it should be reported as an equity transfer. Perhaps, the Committee should consider expanding this paragraph to include such circumstances.

In paragraph 11.27, we believe the reference on top of page 75 needs clarification. It indicates **"There have been material transactions between the health care entity and the related organization."** In such a circumstance, the Guide indicates there should be footnote disclosure. It would appear that in such circumstances, these transactions would be eliminated upon consolidation or combination of the financial statements of the related entities. If consolidated or combined financial statements are not prepared, it would appear that this item could be incorporated into the next paragraph set forth on page 75 relative to section 11.27.

Chapter 12.

Exhibit 12.2 gives an illustration of a Material Uncertainty Related to Medical Malpractice Liability. We suggest that the Committee also include in the Guide an example of a Material Uncertainty Related to a Going Concern situation.

Chapter 14.

Paragraph 14.23 appears to give an option to CCRC entities to amortize deferred revenues on other than a straight-line basis when costs may be at a higher rate in future years. This exception seems to be unique to CCRC's. There are circumstances where other health care providers receive grants or have deferred revenue items that extend over several years. These items are generally amortized on a straight-line basis without regard to increases in future costs. Should such an amortization method as described for CCRC's also be allowed for these other providers as well?

On page 97, in calculating the per resident cost of depreciation, the amount of depreciation relating to revenue producing service areas has been eliminated. Has that been done since the Resident fees paid will not cover such items?

On page 98, $27,027 is being excluded for Unamortized deferred revenue. We were unable to track this number to the illustration provided and ask that perhaps this item be clarified.

Illustrative Financial Statements

As a general comment, we observed that in all of the illustrative financial statements, a Balance Sheet has been presented contrasted to a Statement of Financial Position as required by FASB Statement #117. It is our understanding that one of the reasons for issuing FASB #117 was to obtain consistent reporting and accounting among non-profit organizations. The illustrative financial statements seem to be contrary to that objective. Also, we believe the Committee should reconsider and include a non-operating income caption below the operations line in the Statement of Operations. Such a caption, we feel, should include not only contributions but also interest income, capital gains and losses and net assets released from restrictions related to long-lived assets. Finally, we noted that most of the disclosures to the financial statements indicate that charity care is excluded from gross revenue. Again, we see no major problem with including such amount as gross revenue and also as a deduction from gross revenue since net patient revenue is ultimately reported on the Statement of Operations and request that the Committee reconsider this presentation.

Sample Not-for-Profit Hospital

We feel that in the **Statements of Operations**, the caption presently used of "net assets released from restrictions" be expanded and only include those items "used for operations".

With respect to the **Statements of Changes in Net Assets**, we believe that the repetitive revenue information included in the unrestricted net assets

section, which also appears in the Statements of Operations, is confusing and not helpful to a financial reader. Perhaps, a caption that can be used under the unrestricted net assets section should merely be "Increase in unrestricted net assets derived from operating and other activities."

We also believe that the caption "net realized gains on investments", indicated for both temporarily and permanently restricted net assets, should contain an asterisk to indicate that these amounts only relate to transactions where State law or Donor restrictions require the addition of such amounts to Net Assets. We believe that, without such a reference, the user of the Guide may be mislead into believing that all net realized gains on investments applicable to temporarily or permanently restricted net assets should be added to Net Assets as contrasted to only those required by law or by specific Donor restrictions.

On the **Statements of Cash Flows**, we believe the starting point should be operating income. Such a presentation would eliminate the need to reflect an increase and decrease relative to the "Transfer to parent" and also allow the extraordinary loss to be shown as a decrease in cash flows.

We also are confused as to why the provision for bad debt is specifically set forth as an increase from operating activities as contrasted to being netted in the accounts receivable amount. We understand this item is a non-cash item but so are accruals for expenses. The change on the balance sheet for patient accounts receivable was $1,000,000 less than the amount presented in the statements of cash flows with the difference apparently being the $1,000,000 provision for bad debts.

We believe contributions for charity care should be reflected as an operating activity as contrasted to a financing activity since the cost of providing such care is an operating activity.

We also had difficulty reconciling the cash flow items presented for other current assets, other assets, purchases of investments and proceeds from sales of investments and increases related to long-term debt. Additionally, we did not see any specific reference to changes in Assets Limited as to Use.

Finally, we believe, with regard to supplemental cash flow disclosure information, that it should include a description of contributed capital assets which has no effect on cash flows.

In the **notes of the financial statements**, we have the following comments:

Under the Summary of Significant Accounting Policies, we noted several instances, i.e. cash, charity care, etc., where explanations were used to describe amounts appearing in the financial statements relating to the current year. It was our understanding that accounting policies should be stand-alone items and not in support of specific transactions or amounts appearing in the financial statements for a particular year.

In Note 4 - Property and Equipment, we could not reconcile the depreciation and amortization expense amounts reflected to the amounts reflected in the statements of operations.

For Note 5 - Long-term Debt, we are unsure if there is a requirement to disclose the depreciated costs or amortized costs of assets which are used to collateralize debt.

In Note 11 - Commitments and Contingencies, there is a reference to litigation which seems to be inconsistent with the discussion of litigation set forth in Note 7.

With respect to Note 13 - Related Party Transactions, we question whether the inclusion of a footnote which reflects a Foundation's assets, liabilities and operations is appropriate given that the control of those assets and timing of the transfer of such assets are under the control of the Foundation and independent from the control of the hospital.

Relative to Note 14 - Functional Expenses, we believe that the presentation of functional expenses may not be adequate or consistent with the intent of FASB #117. Also, it seems to be inconsistent with the illustrative financial statement presentations in the Guide used for other Providers. In these latter cases, allocations to various functional programs have been set forth. We believe that functional expense information for hospitals should include, at a minimum, such functional activities as in-patient services, out-patient services, research activities, etc. or nursery care, ancillary and general services.

Some of the foregoing comments, if accepted by the Committee, would also apply to the other illustrative financial statements in the Guide.

Sample Governmental Hospital Financial Statements

We question why the Committee has used the term Fund Balances for these financial statements as contrasted to Net Assets. If GASB requires the term "Fund Balance" and the Committee has adopted such a presentation, we believe the Committee should reconsider its conclusion to present a Balance Sheet since FASB requires a Statement of Financial Position as contrasted to a Balance Sheet for not-for-profit organizations.

In the **Statements of Cash Flows**, we believe the presentation of total cash and cash equivalents of $5,021,000 is perhaps confusing and misleading in that in referencing such amount to the balance sheet, the only amount used for cash and cash equivalents was $4,044,000. The presentation includes cash included in Assets Limited as to Use. It is our understanding that cash and cash equivalents generally should be only those items available for operating purposes. It would appear the amounts included in Assets Limited as to Use do not meet such a definition.

In Note 6, Bank Deposits and Investments, we had difficulty reconciling these amounts to the balance sheet. The note appears to include not only the amounts included in the cash and investment captions reflected on the balance sheets but also includes amounts that are reflected with Assets Limited as to Use. Again, in this case, it seems to be unclear why such a broad caption should be used in the footnotes when details are not specifically set forth on the balance sheets. Also, we are confused as to why the bank balance total is $4,840,000 and the carrying value is $5,021,000. Should not these amounts be the same?

In Note 8 - Pension Plan, there is a reference as to how pension plan financial information can be obtained. This disclosure does not appear appropriate for a financial statement and appears to go beyond the requirement for pension plan disclosures.

Note 10 - Classification of Expenses, does not contain the following statement (the preparer of the financial statements may wish to include a brief description of the types of programs) which is included in the other illustrative financial statements. Perhaps, this reference should also be included in this footnote.

Sample Nursing Home Financial Statement

We believe the Committee should consider presenting a one page balance sheet for its illustration. Also, for both the nursing home and hospital illustrative financial statements, perhaps the caption to reflect the results of operations could be similar to the one used for a Home Health Agency on page 152 of the Guide.

We are unsure of the requirement in Note 2 to disclose the intent of the Board of Directors since the Board of Directors obviously could utilize such cash for operating purposes if it so desired.

In Note 3, we were unable to reconcile the amounts reflected in the note to the amounts shown on the balance sheet.

Home Health Agencies

In Note 6, we also question the requirement for indicating Board designated assets. If such a designation is appropriate here and classified as cash and investments on the balance sheet, should a similar treatment be given in Note 2 of the nursing home illustrative financial statement. In the latter case, the Board Designation amount is included in "Assets Limited as to Use".

Not-for-Profit Ambulatory Care Entities

We noted that a specific accounting policy was set forth for supplies, whereas, a similar policy was not set forth in the hospital and nursing home financial statements. We believe such amount may be as material in the latter settings as well and perhaps should be included in those illustrative accounting policies.

Similarly, we noted that the Depreciation accounting policy only deals with Depreciation as contrasted to also including property, plant and equipment. Property, plant and equipment is a significant amount of the illustrative Ambulatory Care's balance sheet and perhaps should be included in the illustrative note.

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August 1, 1995

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I operate a small firm which has specialized in audits of local not-for-profit agencies of the voluntary health and welfare type. I have been serving not-for-profits for over 20 years and have gained considerable satisfaction through improving financial statements and Board understanding of such financial statements through proper fund accounting, particularly use of property funds and funds functioning as endowment where appropriate. I have also served as board member and treasurer of a not-for-profit church related continuing care community.

I am enclosing a copy of a comment letter I am submitting on the exposure draft, "Audit and Accounting Guide for Not-for-profit Organizations." Much that is in that letter applies here also, and will not be repeated again, except to say that property matters will not be as much of a problem for the health care organizations since in most cases depreciation is recovered through revenues, whereas in many other types of not-for-profit organizations it is not. However, there are situations in the health care field where a significant portion of facility costs has been provided from proceeds of capital campaigns and where the Board of the organization has elected not to try to recover these costs again through revenues. In these cases, I believe a column for the property fund within the unrestricted net assets section to record these assets and the related depreciation as well as a column for the operating fund is essential, to avoid showing the operating loss that would otherwise result. Also, the issue of write-off of such properties under FAS 121 needs to be addressed.

All that the enclosed comment letter says about need for more columns within each of the FAS 117 categories of net assets and need for breakout of capital transactions applies here and is incorporated herein by reference.

While the description of the not-for-profit environment in that letter may not be quite so bad in the health care field, in the case of the health care provider of which I was treasurer, which had annual revenues and total assets in the $3,000,000 area, there never was a highly skilled accountant on the staff who could have handled all accounting matters without my assistance. Most of the Board

would have had very little understanding of the finances of the organization had I not designed proper fund accounting financial statements and explained them to the Board from time to time. Even then, the understanding of some Board members was quite limited. The audited financial statements prepared under the previous edition of the Health Care Provider Audit Guide were so condensed that I was very reluctant to release them to the Board and to our church constituents because they would draw very misleading conclusions that we were very wealthy and needed no financial support, whereas we had a great and growing need for support to cover charitable care.

There are three facets of the operations of a continuing care community that need to be clearly set forth in its financial statements if management is to understand its operations and manage them wisely. These are:

1. What would be the result of operations if all residents paid the established fee and there were no contributions, investment income, charitable care, or life care agreements?
2. What is the amount of charitable care and how is it funded?
3. Are the deposits for life time continuing care adequate and if not, how is any shortfall funded, or if excessive, how is the gain used?

To be responsible to the residents of and creators of a not-for-profit continuing care community, the organization must adopt policies governing each of these areas (i.e. what the goal for item 1) and be able to compare the results of actual operations with the goals. Financial statements which mix these areas together and obscure the three facets are simply unacceptable, in my judgment, but that is what will occur if only the three columns of FAS 117, unrestricted, temporarily restricted, and permanently restricted are presented with no charitable care shown.

I am enclosing a copy of the statement of operations and changes in equity that I designed to comply with FAS 117 for 1994 that shows necessary information about these three facets and how they are funded, which is the key to understanding this organization and its need for support.

The basic philosophy of the organization is that it would earn a small profit (to enable property additions and replacements to be financed) if all residents paid the regular fees. Fees are set on that basis. We represent to our constituency that all contributions received that are not donor restricted for endowment, property additions, or memorials are to be used for charitable care. Thus, they are put into the Charitable Care Fund, which we consider to be donor temporarily restricted. Actually, most of it is from bequests. In light of that, our policy is that the Charitable Care Fund is really funds functioning as endowment for charitable care and that we apply toward charitable care only the current gifts (not including bequests) and the income earned on the fund. All endowment income is applied to charitable care. The Investment Income Fund represents an accumulation of deposits and investment income which has been dedicated to fund care of persons making lump sum payments for life time care. We quit taking people on that basis some years ago because we felt such deals were too risky, due to inflation and unanticipated nursing care. Now, we transfer from it to operations amounts equal to the regular fees that would be paid by such people if they paid monthly. When the last person dies the fund will be combined with Funds Functioning as Endowment. Income on this fund not used for life care is applied to charitable care. Charitable care still not funded from above sources is absorbed by the Operating Fund, in effect charged to other residents through the fee structure. We believe this to be inappropriate, although there is no other way to fund it presently. We have a goal of accumulating sufficient endowment to generate sufficient income to fully fund charitable care. However, since most of the charitable care is made up of the difference between our rates necessary to break even and our Medicaid nursing

home rate, we may never reach that point, particularly if there are significant cuts in Medicaid. Notes to the financial statements describe these funds and the policies regarding them. Such notes on policies should be required.

The Operating Fund column of the statement shows the result of operations, a loss of $6,178 after charitable care but before the funding available therefore and capital transactions and transfers, thus satisfying the needs for disclosure of facet #1 above.

To satisfy facet #2 above, I believe that it is absolutely essential that financial statements clearly show the amount of charitable care and how it is funded and what is funded from general operations (here $190,321 less $128,943) and what is funded from other sources ($128,943). I cannot see any basis for an organization like this to appeal for contributions to subsidize everybody in the facility, including those able to and who expect to pay their own way but who do not expect to pay for charitable care of others. I certainly would not give any money on that basis myself. Note disclosure is not adequate for this extremely vital information. While it is not mandated by FAS 116 and 117, I cannot see why the AICPA should not mandate it in their guide, but rather ban it from the statements. Possibly it is argued that when an organization agrees to participate in Medicaid that they in effect agree to sell their services for what Medicaid will pay, just as they agree to serve private pay persons for the regular rate so all amounts received should be treated the same. That argument is not valid. A charitable church related organization plans to and does serve both people able to pay and those who can pay part or none of the cost of their care. Many people pass from self pay to Medicaid when they require nursing care, but they are not put out on the street when the transition occurs. But the organization must keep track of the cost of their charitable care and fund it if it is to be fair to those paying their way. To show no charitable care in the financial statement is intolerable. Health care providers are different from voluntary health and welfare organizations that serve many people who pay little or no fees and are funded by the United Way, government grants and significant donations and there is no need to compare fees received with cost of services. A charitable health care provider is both running a business operation that must break even if everyone paid the established fees, and a charitable component that must be funded. It must disclose each if it is to be worthy of funding, or I would think even be considered as a 501-c-3 charitable organization by the IRS.

The matter of deposits for life time care needs further attention. If there is much activity of this sort, failure to evaluate separately this component can lead to disaster, even bankruptcy. I am glad to see the Audit Guide devote considerable attention to this area.

While we set up a fund balance of deposits and income thereon, from which we transferred to operations what would have been the fee charged to a monthly pay resident for care, the liability, deferred revenue model may well be more appropriate. This does require separation of the liability from the deferred revenue, a task we did not have. The Audit Guide treatment has problems as follows:

1. We found that the big risks in determining the amount of such a deposit was the amount of inflation occurring over a person's lifetime and the amount of nursing care a person might eventually require. While Section 14.23 says amortization of the deferred revenue <u>may</u> be higher in the later years, it does not say it must be. I believe wherever a continuum of care is guaranteed, costs of care will always be higher in the later years. Experience data should be developed as to average months of supportive care and nursing care required by residents to determine the required deposit. The amortization should be the current regular fees for the residents' present status. Thus the amortization should increase each year by the inflation rate and the moves to more

costly levels of care. Straight line amortization will almost always produce inadequate revenue in the later years. It will dangerously leave a new organization in trouble in future years, which may look good in the years shortly after it opens with a younger average age population than will be present in later years. Also, continuing amortization on the original basis mixes in current operations the true result of current operations with inaccurate actuarial determinations on people admitted years ago. It may thus penalize new residents paying as they go with past actuarial errors on other people.

2. I believe that it is inappropriate to refigure the future exposure each year and adjust to it through an item included in ordinary operating revenue. First, this will distort the bottom line of regular operations which needs to show what operations would be if everybody paid the established fee. Second, it will require small annual loss recognitions on a person every year until death and then a big gain on death. This is because a person's expectancy does not decrease a year when they live another year, but obviously they do not live forever. Also, inflation will increase the liability annually if not allowed for in the original calculation and the basis of amortization. Thus, I believe that in general the liability should not be recomputed and adjusted to annually, and I do not believe that gains on early deaths should be taken up in adjustments because they will be offset in later years by those living longer than their life expectancy. This is a difficult issue, but I recommend that an actuarial calculation be made annually and the result be disclosed in the notes and compared with the liability on the books with a discussion about the methods followed and the limitations thereof. The Audit Guide should allow but not mandate that the organization adjust to the liability by a non operating item when in their judgment adjustment is appropriate but must either adjust every five years or state in the notes why such adjustment is inappropriate.

I will now deal with the two issues on which comments are specifically requested:

1. In my opinion, there is no reasonable basis, except in rare cases where a donor restriction as to use exists, for considering that the donor restriction does not end when amounts contributed for property assets are expended for such assets. The idea that a temporary restriction exists that expires as the assets are depreciated is an effort to avoid showing the loss in the unrestricted net assets that occurs when depreciation is recorded there but there is no attempt to recover depreciation through operating revenues. The only way to properly deal with depreciation on assets purchased from capital campaigns not recovered in operations remains, regardless of FAS 116 and 117, to record the assets in the Property Fund and depreciate them there, with the depreciation considered as a capital transaction not part of operations, and to include separate columns within the unrestricted net assets for the Operating Fund and the Property Fund. This is a basic flaw in the three net asset categories of FAS 117. The Audit Guide should show an example of this treatment and discuss when it is appropriate. Neither the FASB nor the AICPA have any business implying that not-for-profit organizations must plan to recover from operations depreciation on assets already purchased from contributions made therefor, and they have no business mandating financial statement presentations that show the depreciation as an operating loss where there is no attempt to recover it.

2. Capital gains and losses, whether unrealized or realized, are capital transactions and should not be included above the operating income caption or misleading results of operations will be presented. This will be particularly true if adjustment of investments to market are required. If included in operating gain or loss, they will destroy the meaningfulness of that number, and leave it at the mercy of random market fluctuations. I cannot imagine how anybody can seriously propose not having a capital transactions section of the statement of operations. In my view, it would be much as if a for profit company included proceeds of sale of stock as a revenue or adjusted the value of its property to market through a revenue item. I would prefer that investments not be adjusted to market, just as I would not adjust property to market. However, if they must be adjusted, I would have the adjustments go to directly to separately disclosed fund balances within each of the categories of net assets as is now provided in FAS 115 for available for sale securities.

I will comment on one further item. the balance sheet term "assets whose use is limited" is, in my view, inappropriate as it does not describe the nature of the asset. It is an attempt to retain some remnant of fund accounting in a balance sheet that combines all funds. I much prefer to have separate columns in a balance sheet for operating funds (unrestricted and restricted combined, property funds, and endowment funds. If a combined balance sheet is to be presented, I would favor balance sheet captions like, "Money Market Fund Restricted for Property Acquisition" or "Stocks and bonds of Endowment Fund."

In conclusion, I believe that not-for-profit organizations and their auditors will have serious problems in presenting financial statements that comply with recent FASB pronouncements. I believe the AICPA Audit Guides should deal with these problems and make recommendations as to when the three asset category presentation is inadequate and show how it can be expanded in such a manner as to fairly present the information needed by the management and constituency of these organizations.

Sincerely,

Stanley F Dole

SFD/egd

Enclosures: 2

STANLEY F. DOLE
CERTIFIED PUBLIC ACCOUNTANT

1536 EASTLAWN S.E. · GRAND RAPIDS, MICHIGAN 49506
616 245-7271

August 1, 1995

Joel Tanenbaum
File 3605 AG
Accounting Standards Division, AICPA
1211 Avenue of Americas
New York, New York 10036

I operate a small firm which has specialized in audits of local not-for-profit agencies of the voluntary health and welfare type. I have been a board member and treasurer of such organizations. I have been serving not-for-profits for over 20 years and have gained considerable satisfaction through improving financial statements and Board understanding of such statements through proper fund accounting, particularly use of property funds and funds functioning as endowment where appropriate.

Presently I am extremely discouraged and concerned with what I see as the likely results of implementation of FAS 116, 117, and 121, and the exposure draft of Accounting for Certain Investments Held by Not-for-Profit Organizations in such a way as to present virtually meaningless financial statements. I feel that these pronouncements have been issued by people who have very little understanding of the not-for-profit environment who are trying to force these organizations into a business format of accounting except where legalities regarding restrictions prevent that. Fund accounting was created to keep track of the different facets of assets and operations peculiar o the not-for-profit field, not just to deal with legalities. In many situations, it must survive if the financial statements are to make sense. I am enclosing copies of comment letters which I sent on these statements, which were ignored.

I realize that the AICPA cannot repudiate the FASB. However, there are a lot of areas where FAS 117 leaves room for more expanded detail presentations, and I believe the Audit Guide should discuss such presentations, show examples of them, and set forth recommendations on when and what detail should be presented. I am very disappointed that the Audit Guide does not do so.

I also believe that there will be many organizations that will decide that they cannot comply with these pronouncements and still present meaningful financial statements, or who refuse to make the effort to, or who are unwilling to, break out a lot of their endowment and call it unrestricted as provided in FAS 117 or write off their property as provided in FAS 121. I believe that the Audit Guide should discuss what accountants report could be issued under these circumstances. I see no reason why if audited financial statements can be issued on an Other Consistent Basis of Accounting such as the cash basis, they cannot be issued on the basis of the Audits of Voluntary Health and Welfare Organizations Audit Guide. After all, even though superseded, it is an Other Consistent Basis of Accounting, much better than the cash basis, and I believe very appropriate in many situations. I believe the new guide should discuss this possibility.

The not-for-profit environment that I work with every day and that the Audit Guide should be concerned with has the following aspects:

1. The vast majority of these organizations are small. Few organizations with under $1 million in revenues or assets elect to devote enough resources to the accounting function to employ even one skilled accountant. Since their purpose is to serve people, not conform to accounting

pronouncements, this is a responsible decision as to employment of limited resources. There are few skilled accountants on client staffs.

2. Executive Directors are usually social workers, not very knowledgeable on accounting matters.

3. Most Board members have little financial or accounting expertise.

4. Financial statements issued by the organization during the year are often on the cash basis essentially and usually present transactions only of the General Operating Fund.

5. There are three components of an organization's operations that the Executive Directors, Boards, and their constituencies need to be aware of to properly evaluate performance. These are:

a. Did they gain or lose on ordinary (General Fund) operations, and were there any unusual items or capital transactions included in these results?

b. How, if at all, are they providing for property additions and replacements? How much, if any, depreciation is being recovered in operations? (Invested in Property Fund and Capital Campaign or Property Additions Funds).

c. Are they building up endowment capital (Endowment Fund, including Funds Functioning as Endowment)? What capital (normally bequests and capital campaigns) was received and how was it applied? Are they spending more or less than the investment income earned? What is being done with capital gains and losses?

Traditional fund accounting was developed to fairly present these three facets. The three categories of net assets of FAS 117 makes a fair presentation of these facets very difficult.

6. There are usually many errors in the accounts and audit adjustments that need to be made if errors material to the detail are to be corrected.

7. Many auditors do not understand the not-for-profit field, take on some audits as charity work, fill in work for juniors, or to promote themselves for more business. They wish to hold their time to a minimum, and wish to present as condensed statements as possible so that they do not have to be concerned with errors that may not be material in condensed statements but are material to the detail.

8. Since the organization does not prepare adequate internal financial statements, the management, Board, and constituency will never see the true position of the organization unless the annual audit shows the above three facets described in #6 above, and presents full detail financial statements. It is not correct to state that management can have whatever internal statements they need. The organizations generally do not have the capability of preparing such statements.

9. Many auditors, unless warned that the three columns unrestricted, temporarily restricted, and permanently restricted, do not fully set forth the above three facets, will present statements with only those columns, and seriously misleading statements will result.

10. Management, Boards, and constituencies are very grateful when an audit gives them the information they need and an auditor explains the three facets and shows them in the statements. Then they have a positive view of the profession. When statements are too condensed to be meaningful, people have a low opinion of the profession, assume that the audited statements are some unintelligible mystery that has little or no relation to the statements they have seen, and say, "I guess we have to have the audit to prevent thefts from the organizations." That is hardly the image we want as a profession.

I will now discuss the problems that I see in the FAS 117 format and what guidance I believe should be in the Audit Guide.

The major problem is that an unrestricted net assets column combining operating assets, property assets, and funds functioning as endowment will not be meaningful nor will a temporarily restricted column combining a capital campaign fund, restricted grants, funds raised for spending next year, and property assets. Therefore, the Audit Guide must discuss when two or more columns need to be shown within each of the three FAS 117 columns to give a fair presentation.

A second problem is that FAS 117 does not mandate that non operating or capital transactions such as bequests, capital campaign gifts, and capital gains be broken out. In order to present fairly the results of operations, these must be broken out and the Audit Guide must discuss the nature of items that should be broken out and how they should be presented. This is particularly important if investments must be adjusted to market. I find the treatment on Appendix C of FAS 117 to be absolutely appalling where an $8,228 item, "Net unrealized and realized gains on long-term investments", out of a total increase in unrestricted net assets of $11,558 is not broken out. If items like that are included in operations, very misleading impressions will be given and operations will be all over the map, depending on market fluctuations. I believe that it should be mandated that bequests not be buried in contributions, which may be assumed to be representative of normal income, but must be shown separately as capital transactions.

I know that I could not express an opinion that an only three column financial statement with no break-out of capital transactions was a fair presentation in some of these situations regardless of what FASB says.

Property funding is much different in the not-for-profit field than in for-profit enterprises. While there are some organizations where depreciation is properly an operating item (such as hospitals where it is in the rate structure and organizations without major properties), in many organizations such as colleges, churches, and health and welfare organizations, current budgets do not anticipate that depreciation will be recovered. College tuition, church current expense pledges, and government, foundation, and United Way grants and ability to pay fees of voluntary health and welfare organizations almost never recover depreciation. While there may be small items of equipment financed from operations, any significant property acquisitions are funded by capital campaigns. Obviously if the building is already paid for by a building fund campaign, the operating budget does not need to recover this cost. Therefore, if the depreciation is in the unrestricted column, an unreal loss will result. FAS 117 tries to solve this problem by allowing the building to be considered as temporarily restricted, with a transfer made from therefrom to unrestricted to offset the depreciation. This is a poor answer. As far as I can see, once a gift for property is expended, the restriction is gone and the building is unrestricted, except in very rare cases where some continuing restriction as to use exists.

There is really no satisfactory way to deal with this other than to have a Property Fund where the depreciation is recorded. Where the building is in the unrestricted column as an asset, the depreciation results in an unreal loss and what is even more dangerous, results in an apparent large unrestricted net asset balance. This can be very misleading, making people believe the organization is comfortable financially in cases where the building net value exceeds the unrestricted balance, leaving a real operating fund deficit balance. While there is no good way to deal with this under FAS 117, I believe that the audit Guide should discuss the problem and recommend that where significant assets have been purchased from proceeds of capital campaigns, the presentation for unrestricted net assets should contain a column for the Operating Fund and a column for the Invested in Property Fund, and a total column to satisfy FAS 117. Further, capital campaign proceeds and depreciation on items purchased from capital campaigns should be recorded in a non operating section called Capital Transactions and Other Changes in Fund Balances to make clear the true nature of these transactions.

A property problem not addressed by the Audit Guide is FAS 121 impairment write-off of assets where the cash flow thereof will not recover the carrying value being applied to not-for-profit organizations in error. As stated above, in most cases of significant property assets purchased from capital campaigns, there is no possibility of cost recovery through operations so write-off would be mandated by FAS 121. People do not

understand that there is usually no cash flow from property assets in the not-for-profit field. I have had to explain to bankers who have made construction loans that there was no way that cash flow would enable their debt to be repaid and that they must rely on contributions to retire the debt. I do not believe the FASB understood what they were doing there. To me, it shows they simply do not understand the not-for-profit sector. I do not know what can be done about this, but I do not believe the Audit Guide can ignore it now that FAS 121 has been issued.

I believe that there are many situations where all or the part of property which operations is expected to fund should be recorded in unrestricted assets (Operating Fund) and depreciated there. Then FAS 121 could apply to that. I believe that Audit Guide should discuss when it is appropriate to put property in general unrestricted net assets and when a separate Property Fund column within unrestricted net assets is appropriate.

The treatments of funds functioning as endowment (Board designated endowment and apparently also, and I believe erroneously, capital gains realized and unrealized on donor restricted endowment) and unrestricted bequests need to be addressed by the Audit Guide.

Not-for-profit organizations do not have stockholders investment and generally do not have long-term debt as capital. However, if they are to be solvent, increasingly they must have capital funds. A wisely managed organization will regard bequests as capital funds and put them in endowment. Unfortunately, it is true that most attorneys urge clients to make charitable bequests unrestricted, believing that the organization can best decide where to use them. However, it is my experience that donors of bequests want to see their bequest used to benefit the organization over the long term, and would be very upset if they knew that their bequests were just put into the operating pot and spent in the year received. However, FAS 117 encourages that, and does not specify that bequests even have to be broken out of contributions or be treated as capital transactions. I believe the audit Guide should discuss this issue and recommend that unrestricted bequests should be designated by Boards as fund functioning as endowment and should be treated as capital transactions. I also believe that the guide should state that where there are unrestricted funds functioning as endowment that transactions therein should be shown in a separate column within unrestricted net assets, and that capital gains and losses, realized or unrealized, and bequests, should be included as capital transactions. This would at least prevent presentations which made an organization look good by offset of operating losses by bequests and capital gains.

The following comment relates to the issue of recording tuition at colleges and universities. I have audited colleges, and my wife is chair of the board of a small church related college, so I am knowledgeable about this issue.

I believe that a college needs to show what student aid and scholarships it is awarding and that the need to raise the funds to cover these costs is a major concern. The financial statements need to show these costs so that the funds available therefor (endowment income and contributions) can be compared to the costs.

The situation has been complicated recently when the practice of tuition discounting has become more prevalent. This is the practice of giving more aid than would be justified by need in order to attract a student who is desired because of academic strength, sports ability, or other skills, where the student does not qualify for any specifically funded awarded scholarship.

While the administration certainly needs to know how much of this is going on and the governing board needs to know the amount in order to control it, it is really hard to treat these discounts any other way than a retail business would treat a markdown. Institutions probably would not like to disclose the amount of tuition discounting, lest it encourage other prospective students to demand it. I conclude I would be willing to see it reported only internally, but I would not ban disclosure. It may be difficult to separate discounts from true aid, but I believe an institution must do so in order to manage properly, and thus the separation should not be an unreasonable burden.

The exposure draft does not give much attention to implementations issues regarding the FAS 116 position on contributions. My comment letter discussed a number of situations where FAS 116 violated

appropriate treatment of contributions, particularly those for future years such as a fall United Way campaign for funds for grants awarded by the United Way for the following year.

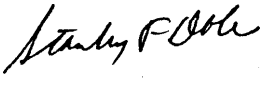
Some discussion should be included about the misleading effect of including such pledges in fund balance without the offset of the grants payable if awarded in the following year. Advice could be given that the organization be urged to make the awards in the same year in which the pledges have to be recorded to at least get a matching of revenue and expense. Even then, I cannot see a possible reasonable presentation under FAS 116 and 117 when all expense, including grants for future years, is to be recorded in unrestricted, while the revenue is in temporarily restricted and still there at year end leaving a big unrestricted deficit for the grants already awarded. Under this approach, most of what would be recorded in a year would really be the next year's operations.

This problem also arises when foundations make three year pledges to capital campaigns out of endowment income they expect to earn in the three years, yet must record the pledge payable when made. It also applies to church pledges solicited in the fall for operating expense the next year, the typical situation.

I believe this intolerable mess must be reconsidered by the FASB, but lacking that, the Audit Guide should at least discuss the problem. Also, it should discuss treatment in internal financial statements. Do all such pledges receivable for the following year transfer from temporarily restricted to unrestricted on January 1 or pro rata over the year? Of course, what is actually needed for internal statements in a church, is a comparison of cash collections with accrual basis expenses. The guide should so state.

Somehow the FASB must get real in these situations or the AICPA must point out the problems in the Audit Guide if it is to maintain any integrity. The Audit Guide cannot merely ignore the problems and confine its efforts to discussion of appropriate auditing procedures. I believe auditors know what are proper auditing procedures. What they do not know is how they can come closest to making sense out of these basically inappropriate FASB pronouncements. We must try our best to help them and use the Audit Guide project as a tool to work with the FASB to get them to correct as much of the damage as possible. I think that it is most inappropriate to issue the Guide only considering FAS 116 and 117 and ignoring 121 and the proposed FAS "Accounting for Certain Investments Held by Not-for-profit Organizations." These additional documents offer a good excuse to delay issuance of the Guide to incorporate them and to engage in further discussion with the FASB about the practical difficulties in implementing their pronouncements, which may be a good theoretical model, but make little sense in the real not-for-profit environment.

Sincerely,



Stanley F. Dole
SFD/egd

Enclosures: 2

YEAR ENDED DECEMBER 31, 1994

DESCRIPTION:	UNRESTRICTED NET ASSETS / BOARD DESIGNATED FUNDS: OPERATING FUND	FUNDS FUNCTIONING AS ENDOWMENT	INVESTMENT INCOME FUND	TOTAL
SUPPORT & REVENUE:				
Contribution for Char. Care				
Fees to Residents at Reg Rates:				
Private Pay	2343289		-16998	2326291
Medicaid	802775			802775
Medicare	195481			195481
Less Char. Care	-190321			-190321
Net Fees received	3151224	0	-16998	3134226
Investment Income		7507	36169	43676
TOTAL SUPPORT AND REVENUE	3151224	7507	19171	3177902
PROGRAM EXPENSES:				
Nursing Services	1307959			1307959
Dietary	717859			717859
Building & Grounds	408198			408198
Housekeeping & Laundry	159548			159548
Resident Services	87324			87324
TOTAL PROGRAM EXPENSES	2680888			2680888
UNALLOCATED EXPENSES:				
Management & General	262996			262996
Depreciation	176616			176616
Interest & Financing costs	36902			36902
TOTAL UNALLOCATED EXPENSES	476514			476514
TOTAL EXPENSES	3157402			3157402
Excess of revenues over expenses before capital transactions and transfers	-6178	7507	19171	20500
CAPITAL TRANSACTIONS & TRANSFERS:				
Realized gains on sale of investments			52483	52483
Non operating contributions				
Bequests		67607		67607
Transfer funds available for C Care (CHARITABLE)	128943	-6907	-33824	88212
Interest on interfund borrowing	-14652		14652	0
Transfer property additions	25808			25808
TOTAL CAPITAL TRANSACTIONS & TRANSFERS	140099	60700	33311	234110
Increase/Decrease in Fund Balance	133921	68207	52482	254610
FUND BALANCE AT BEGINNING OF YEAR	712215	87435	672213	1471863
FUND BALANCE AT END OF YEAR	846136	155642	724695	1726473

----- TEMPORARILY RESTRICTED NET ASSETS -----				PERMANENTLY RESTRICTED NET ASSETS	
CHARITABLE CARE FUND	PROPERTY ADDITIONS FUND	MEMORIAL FUND	TOTAL	ENDOWMENT FUND	TOTAL
25685			25685		25685
					2326291
					802775
					195481
					-190321
	0	0		0	~~3159911~~ 3134,126
45621			45621	6907	96204
71306	0	0	71306	6907	3256115
					1307959
					717859
					408198
					159548
					87324
					2680888
					262996
					176616
					36902
					476514
					3157402
71306			71306	6907	98713
74719			74719		127202
	34107	3545	37652		37652
10000		32075	42075		109682
-81305			-81305	-6907	0
			0		0
	-20808	-5000	-25808		0
3414	13299	30620	47333	-6907	274536
74720	13299	30620	118639	0	373249
731691	27454	15008	774153	155174	2401190
806411	40753	45628	892792	155174	2774439

COMMENT
(by H. Selwyn Torrance)
on Chapter 14 of the
EXPOSURE DRAFT
of the
PROPOSED AUDIT AND ACCOUNTING GUIDE
for
HEALTH CARE ORGANIZATIONS
(AICPA Publication 800086)

INDEX

COMMENT

1. **Introduction**
   This comment relates to Chapter 14, "Financial Accounting and Reporting By Continuing Care Retirement Communities". It is from the point of view of an actuary preparing studies for such communities.

2. **Actuarial Viewpoint**
   I welcome the formalization of relevant accounting standards for CCRCs, especially the recognition of the obligation for provision of future services, but I urge that a rather different approach be taken, as discussed below.

   As currently written, the Guide contains some features that are undesirable, and some that are contrary to sound financial principles.

   Specifically, actuaries are trained to apply techniques that will better assess the financial soundness of CCRCs, in accordance with principles set forth in "Actuarial Standard of Practice No. 3 - Practices Relating to Continuing Care Retirement Communities" adopted by the Actuarial Standards Board, and most recently revised in July, 1994 (enclosed as an exhibit).

P/s. call me if you'd like to see exhibit

Studies in accordance with these standards can reach quite different conclusions as to the solvency of a CCRC than would appear from a balance sheet on the principles set forth in the Guide. In my view, the actuarial study is more informative, and is better able to achieve a proper balance between the interests of successive generations of occupants.

Accounting Guides have a considerable influence. For example, I recently encountered an instance where State regulations applying to CCRCs required an actuarial report, but nevertheless required accounting for entry fees in accordance with SOP 90-8 even though the CCRC wished to retain the suitable actuarial method it had already voluntarily adopted.

I urge that your Guide be modified to permit and even encourage the use of actuarial methods.

3. **Accounting for Nonrefundable Advance Fees**

This is one component of the Guide that is relatively straightforward to consider in isolation. See Paragraphs 14.26 - 14.27, paragraph 14.23, and exhibit 14.1.

Let's focus, in particular, on the example of Resident B in Exhibit 14.1:

Resident B	Unamortized Deferred Revenue	Estimated Remaining Life (In Years)	Income
Year 5	$30,000	6.1 =	$4,918
6	25,082	5.8 =	4,324
7	20,758	5.5 =	3,774
8	16,984	5.3 =	3,205
Unamortized deferred revenue recognized upon death of the resident			13,779

Note that the income declines year by year, contrary to what the CCRC may need. Then suddenly, in the year of death, it soars. Even when averaging over a large number of residents, this can create a volatility and unpredictability in the recognition of income that is unacceptable. Simply stated, this is not a good amortization basis.

In a new community, with occupants generally younger than when the community would mature, this basis can be misleading in producing too much income in the early years, and a false expectation that this will continue.

Fundamentally objectionable is that this is decribed as "amortization to income ... based on the estimated life of the resident". This gives a false impression

that actuarial techniques are being used when, in fact, they are not.

A more appropriate description of your method is "amortization to income over the actual lifetime of the resident, with progressive dilution of income on survival. The amount prior to death is determined on a declining balance method, and in any year is equal to the remaining individual unamortized balance divided by the remaining estimated life of the resident. The amount upon death in any year is equal to the remaining individual unamortized balance at the beginning of that year. "

This recognition of the remaining unamortized balance as income upon death is entirely unsuitable. A CCRC is like an insurance company in miniature. Imagine an insurance company selling an annuity product. Suppose that when an annuitant died early, the auditors compelled the company to recognize the unused reserve as income instead of pooling it to take care of others who were unusually long- lived. Even if its estimate of average life expectancy were correct, that company would show misleading profits in the short-term, but losses in the long term.

The actuarial method of amortization that I believe is most widely used, pools the experience. It would result in recognition of income of $4,918 in the first year, as above, and recognition of $4,918 in every subsequent year of survival, subject to adjustment based not on individual experience but on the overall experience of the community as a whole. If the experience on average was as expected, the amortization would remain $4,918 each year, ceasing upon death.

This point is illustrated by the attached exhibit, prepared for purposes of this illustration on a highly simplified basis, ignoring changes in living or nursing care status, using the GAM 83 (Females) mortality table, and assuming that deaths and replacements occur at year-end. All occupants are assumed to be initially age 80 (female, lone), to be replaced on death by others aged 80. Occupancy is 400 persons.

You can see that, on the basis set forth in your Guide, the income recognized is initially 5.3m (in my opinion, too high), falling ultimately to 3.7m. The consequence is that the unamortized income falls ultimately to 21.1m whereas, on the actuarial basis where a constant income of 3.7m has been recognized each year, the unamortized income falls ultimately to 28.3m. Suppose that at some future time not all units could be filled, resulting in a reduced intake of new entrents: Then on the actuarial basis, the constant per capita amortization could still be maintained; whereas on the basis set forth in your Guide, the per capita amortization would necessarily fall, thus aggravating what may already be a distressful situation.

The above applies if the mortality assumptions are fulfilled. Similar comparisons

could be made on mortality rates differing from those used in calculating life expectancies, creating gains or losses, and the actuarial basis would be shown to remain the more stable basis.

If necessary, the actuarial basis can be revised so that it, too, provides for immediate recognition of unamortized income on death -- but with a level total result if assumptions are realized, rather than the declining result obtained on the Guide methodology. The level expected income will then be the total of income recognized on survival and income recognized on death; however, the income on this basis may be volatile, depending on the incidence of actual deaths. Immediate rather than spread recognition of experience inevitably results in this volatility, and prevents any reliable budget being formulated for the current year.

The actuarial basis can also be revised, probably more readily than the basis described in the Guide, to deal with "circumstances when costs are expected to increase at a significantly higher rate than future revenues in the later years of residence". The income can be indexed, for example, to parallel expected increases in costs after transfer to various levels of nursing care.

4. **Obligation for Provision of Future Services**

In principle, the requirement to calculate this obligation and include it in the balance sheet is a welcome development.

I note, in particular, that general and administrative expenses are proposed for inclusion in cash outflows under the Guide, whereas under SOP 90-8 they were excluded. I believe this is a desirable change.

However, there are deficiencies in the methodology used, and consequently little reliance can be placed on the resultant balance sheet and apparent solvency.

(a) The Guide focusses on whether the community shows a deficit or surplus. By contrast, under the actuarial method, the financial condition of a CCRC is considered in satisfactory actuarial balance only if all of three entirely different conditions are met. (See Section 5.1 of the Actuarial Standard of Practice No. 3.)

(b) The obligation is recorded as zero when it is found to be negative, i.e. a net asset. This is shortsighted, and may result in finding a deficit when the community is in fact solvent, e.g. where future fees are expected to suffice to cover repayment of past debt even after allowing for other expenses.

(c) The specific mention of "interest expense" as a cash outflow is inappropriate. All that need be discounted is any difference between the interest actually payable and that which would be payable on the discount rate used.

For example, consider a $1m loan, repayable in 10 years, where $50,000 interest (i.e. 5%) is also payable thereon each year for 10 years. If the value is found by discounted at 5% the combined value of principal and interest is $1m. (If it is discounted at 6% the value is less). This $1m value is the total of two parts, the discounted value of the repayment (approx. $613,913) and the discounted value of the interest (approx. $386,087). However, the $1m already appears as an obligation on the balance sheet. It is presented in this manner on traditional accounting principles, rather than as the discounted value of the amount to be repaid after 10 years (approx. $613,913). Thus, to prevent double-counting, the additional obligation (or asset) included in the "Obligation for Future Services" calculation should NOT recognize the value of the interest (already included in the $1m), but should recognize only any difference in value arising from a difference between the interest actually payable and that which would be payable if calculated based on the discount rate used.

(d) If special mention is made of "interest expense", why is no special mention made of "interest income", i.e. the return on invested assets? The same principle applies, namely the calculation should recognize any difference between interest actually receivable and that which would be receivable if calculated based on the discount rate used. Typically this would increase the obligation where assets are restricted and not able to be invested to earn a return as high as the discount rate, or where the asset is not producing income.

(e) The illustration provided in Exhibit 14.2 estimates cash flows based on the occupants' estimated remaining life, and then applies discount factors thereto. This method is inaccurate and misleading, and I urge that it should not be given any official backing. The actual cash flows attributable to current occupants immediately change because of early deaths, and continue for a far longer period than the average because of those who are long-lived. The estimated remaining life is only an average. When discount rates are applied, the weighted average differs from the unweighted average. The value of the cash flow is understated for this reason in the case of a female aged 80 by approximately the following amounts, depending on the discount rate used:

Discount Rate	Percentage by which the value is understated
2.50%	3.8%
5.00%	6.7%
7.50%	8.9%
10.00%	10.4%

The understatement is even more considerable for projections that are during the joint life and survivorship of two lives, or for younger persons.

(There is also a temptation to use the incorrect method not just for valuation purposes but also for projecting actual cash flow. Such a cash flow projection would be totally incorrect, for any future year.)

(f) The Guide shows that the depreciation of the facility must be charged where "related to the contracts", but it does not explicitly refer to other fixed assets, nor to future anticipated increases in such assets nor to their replacement. It is not clear which of these are intended to be included as "anticipated cost increases affecting these operating expenses".

I believe that calculations under SOP 90-8 have generally failed to take into account costs of replacement during the lives of current residents in a rational manner.

This comment is closely tied to the topic under the next heading.

5. **Recognition of Costs for Physical Assets.**
I believe that the accounting for the physical assets of a CCRC needs to be done in a systematic manner, including recognition of the incidence and cost of replacements, and allocating an appropriate part of such cost (after discounting) as an obligation of current residents. I would like to see this approach endorsed in the Guide.

My views on the appropriate methodology for this are set forth in the paper "Actuarial Accounting for the Physical Assets of a CCRC" that was published in the 1993 Proceedings of the Conference of Consulting Actuaries (Vol. XLIII). A reprint is enclosed herewith as an exhibit.

— Please call Annette if you'd like to see this exhibit.

6. **Conclusion**
The proposed Guide suffers from a number of deficiencies in its application to CCRCs.

As a short term measure, I urge that this be acknowledged, and that it permit alternatives prepared by qualified actuaries in conformance with Actuarial Standard of Practice No. 3.

I also urge that a panel comprised of representatives of both our professions work to try to resolve areas of difference, and to establish requirements that better serve the public interest.

ABOUT THE AUTHOR

This comment was prepared by H. Selwyn Torrance.

He is an actuary consulting with CCRCs on behalf of Hay/Huggins Company, Inc. He is a member of several actuarial organizations including the American Academy of Actuaries.

He collaborated (with David L. Hewitt) in writing the paper described above on "Actuarial Accounting for the Physical Assets of a CCRC".

EXHIBIT - SCHEDULE ON ACCOUNTING FOR NON-REFUNDABLE ADVANCE FEES

		Basis in SOP 90-8				Actuarial Basis	
Year	Average Age	Deferred Income at BOY	Income from Survivors	Income from Deaths	Total Income	Deferred Income at BOY	Total Income
1	80.0	40,000,000	3,578,329	1,717,800	5,296,129	40,000,000	3,738,895
2	81.0	36,421,671	3,415,127	1,727,584	5,142,710	37,978,905	3,738,895
3	81.9	33,177,070	3,252,235	1,722,129	4,974,364	36,138,118	3,738,895
4	82.7	30,283,568	3,092,746	1,703,086	4,795,833	34,480,084	3,738,895
5	83.5	27,751,755	2,939,788	1,672,425	4,612,212	33,005,209	3,738,895
6	84.2	25,584,685	2,796,356	1,632,682	4,429,038	31,711,456	3,738,895
7	84.9	23,777,549	2,664,898	1,588,726	4,253,624	30,594,463	3,738,895
8	85.4	22,319,985	2,547,586	1,543,302	4,090,888	29,651,627	3,738,895
9	85.9	21,195,679	2,446,235	1,498,762	3,944,997	28,879,313	3,738,895
10	86.3	20,382,594	2,361,725	1,460,329	3,822,054	28,272,330	3,738,895
11	86.6	19,860,537	2,295,752	1,424,878	3,720,630	27,833,431	3,738,895
12	86.9	19,594,754	2,248,866	1,393,670	3,642,536	27,549,383	3,738,895
13	87.0	19,542,565	2,220,386	1,369,127	3,589,514	27,400,834	3,738,895
14	87.1	19,660,212	2,208,943	1,352,114	3,561,058	27,369,099	3,738,895
15	87.1	19,902,014	2,212,339	1,342,881	3,555,220	27,433,064	3,738,895
16	87.1	20,222,338	2,227,655	1,341,044	3,568,700	27,569,712	3,738,895
17	87.0	20,577,761	2,251,440	1,345,617	3,597,057	27,754,940	3,738,895
18	86.9	20,929,216	2,280,075	1,354,700	3,634,775	27,964,555	3,738,895
19	86.8	21,236,250	2,309,124	1,366,783	3,675,907	28,167,469	3,738,895
20	86.7	21,475,341	2,335,190	1,379,957	3,715,148	28,343,571	3,738,895
21	86.6	21,637,474	2,356,105	1,392,412	3,748,517	28,481,956	3,738,895
22	86.5	21,722,183	2,370,608	1,402,768	3,773,376	28,576,287	3,738,895
23	86.4	21,736,575	2,378,373	1,410,180	3,788,553	28,625,159	3,738,895
24	86.4	21,694,029	2,379,949	1,414,361	3,794,310	28,632,271	3,738,895
25	86.4	21,610,739	2,376,440	1,415,494	3,791,934	28,604,395	3,738,895
26	86.4	21,506,186	2,369,511	1,414,191	3,783,702	28,552,881	3,738,895
27	86.5	21,397,757	2,360,841	1,411,233	3,772,074	28,489,259	3,738,895
28	86.5	21,299,365	2,351,925	1,407,421	3,759,346	28,424,045	3,738,895
29	86.5	21,220,619	2,343,932	1,403,465	3,747,397	28,365,749	3,738,895
30	86.6	21,166,585	2,337,635	1,399,908	3,737,543	28,320,217	3,738,895
31	86.6	21,137,990	2,333,392	1,397,095	3,730,486	28,290,270	3,738,895
32	86.6	21,132,068	2,331,199	1,395,174	3,726,373	28,275,938	3,738,895

(See lower part of Page 3 of Comment.)
(BOY is an abbreviation for Beginning-of-Year.)

ACTUARIAL STANDARD
OF PRACTICE
NO. 3

PRACTICES RELATING TO CONTINUING CARE RETIREMENT COMMUNITIES

Revised Edition

Artical not reproduced in Web version

Revised by the

Committee on Continuing Care Retirement Communities

of the American Academy of Actuaries

Adopted by the

Actuarial Standards Board

July 1994

(Doc. No. 048)

Article not reproduced in Web version

Actuarial Accounting for the Physical Assets of a CCRC

By David L. Hewitt and H. Selwyn Torrance

Moody's Investors Service

John Goetz
Vice President, Assistant Director
Health Care Ratings
Public Finance Department

August 3, 1995

Annette J. Schumacher
Technical Manager
File H-1-500, Federal Government Division
American Institute of Certified Public Accountants
1455 Pennsylvania Avenue, NW
Washington, DC 20004-1081

Dear Ms. Schumacher:

We have reviewed the AICPA's Exposure Draft of the Proposed Audit and Accounting Guide for Health Care Organizations. Below are our comments relating to the disclosure of (1) the natural classification of expenses, (2) operating and net income, and (3) assets whose use is limited.

Natural Classification of Expenses

Financial Accounting Standards Board (FASB) No. 117's requirement that not-for-profit health care organizations replace the natural classification reporting of expenses with a functional basis of reporting gives us significant concern. The Proposed Audit and Accounting Guide (Audit Guide) does not provide additional comfort. While Section 10.17 of the Audit Guide states that "(e)xpenses ***may be*** reported on the face of the financial statements using ***either*** a natural classification or a functional presentation" (emphasis added), it does not appear to require natural classification reporting.

While there is no doubt that the reporting of expenses on a functional basis provides information not available using natural classification, the reporting of expenses by natural classification provides valuable information for credit analysis. Depreciation, amortization, bad debt, and interest are a few of the expenses key to calculations providing information about net revenues available for debt service, debt service coverage ratios, liquidity, and accounts receivable and accounts payable days outstanding, among others. Furthermore, trends in expenses by natural classification provide information on labor versus non-labor charges, and cash versus non-cash charges. To report expenses only on a functional basis would obscure these distinctions.

Due to the large number of health care organizations that have issued rated debt, we feel the loss of natural expense classification would be burdensome to the credit analysis process. Therefore, we recommend that expenses be reported on a natural classification basis. We prefer that the natural classification of expenses be reported in the financial statements rather than in the footnotes.

Operating and Net Income

Another concern with the adoption of FASB No. 117 by health care providers is the potential loss of the distinction between operating and nonoperating income. We fully support the Audit Guide's recommendation requiring health care organizations to clearly label total income or loss from operations. However, we do have concerns regarding the definition of operating income.

It is recognized that health care organizations define operating income differently, including an extreme variance in the classification of investment income. The interest, dividends, gains and losses earned on cash and investments held for non-operating purposes should not be included in operating revenues. However, operating earnings may be considered to include earnings on debt service reserve and debt service payment funds held by trustee (offsetting borrowing expenses) or earnings on self-insurance reserves (offsetting insurance expenses). We view earnings on board-designated assets as nonoperating income, with such income incidental to the purpose of the operation.

We support the labeling of operating income or loss. However, we recommend further clarification on operating and nonoperating income, especially regarding investment earnings.

Assets Whose Use Is Limited

Assets whose use is limited generally consists of both unrestricted and restricted assets, with the detail of the distribution of these assets another vital component of credit analysis. Section 1.14 of the Audit Guide states that such detail "generally is disclosed" and "may be provided", however, a detailed breakdown is currently not mandated.

The distinction between unrestricted and restricted assets is an important first step. A more comprehensive breakdown of unrestricted assets, however, would further enhance credit analysis. This breakdown could consist of :

- board designated assets for capital expenditures
- board designated assets for self-insurance
- trustee-held assets for debt service reserve and debt service payment
- trustee-held assets for construction

Thank you for your invitation to submit comments. If there are any questions, please contact me or Kay Sifferman (212-553-4574).

Sincerely,

John Goetz

Masonic Homes
of the R. W. Grand Lodge F. & A. M. of Pennsylvania

JOSEPH E. MURPHY, N.H.A.
Executive Director

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August 8, 1995

Ms. Annette J. Schumacher
Technical Manager
File H-1-500
Federal Government Division
AICPA
1455 Pennsylvania Avenue, NW
Washington, D.C. 20004-1081

Dear Ms. Schumacher:

I am writing with specific comments on the Exposure Draft of the Proposed Audit and Accounting Guide for Health Care Organizations dated April 14, 1995 (Exposure Draft). I am responsible for the financial reporting for a large, not-for-profit health care operation consisting of a 433-bed skilled nursing facility, a 236-unit CCRC, a 58-unit apartment complex for the elderly, and a 283-bed congregate living complex. Our total assets (unrestricted, temporarily restricted, and permanently restricted) average approximately $305 million with total annual revenues (unrestricted, temporarily restricted, and permanently restricted) of approximately $59 million. My concerns are with following issues:

Accounting for Investments (comments specifically requested by the AICPA Health Care Committee)

Earlier this year the Financial Accounting Standards Board (FASB) issued an exposure draft titled "Accounting for Certain Investments Held by Not-for-Profit Organizations." FASB's exposure draft would require not-for-profit organizations to report their debt and equity securities at fair value. Unrealized gains and losses would be reported in the organization's statement of activities. The AICPA Health Care Committee (Committee) asked whether the changes in the valuation allowance for debt and equity securities should be included above the operating income caption in the statement of operations.

I believe that changes in the valuation allowance for debt and equity securities should be included **below** the operating income caption in the statement of operations. This is especially true for not-for-profit organizations that are less likely than for-profit organizations to use their investment portfolios to increase net income. Inclusion of changes in the investment valuation allowance with operating

income hinders analysis of a health care organization's primary mission - the provision of health care services.

For example, approximately 60% of our organization's total assets consist of board designated and endowment fund investments. The change in investment valuation allowance from year to year could potentially be very large when compared with our revenues from providing health care services. Reporting the change in the investment valuation as a component of operating income would significantly detract from our ability to assess the effectiveness of our health care operations, where management devotes most of its efforts. The ability to assess the effectiveness of our health care operations is important not only to our Board of Directors, but also to the people who contribute to our organization and to holders of our tax exempt bonds.

Although our specific situation may be unique compared with other organizations, the importance of analyzing the effectiveness of an organization's primary mission exists for all not-for-profit health care providers. The generation of realized and unrealized appreciation is, at best, a secondary mission of health care organizations. Therefore, changes in the valuation allowance for debt and equity securities should be reported below the operating income caption in the statement of operations.

Flexibility in Classification of Activities on the Operating Statement

The Exposure Draft incorporates the financial reporting requirements of Financial Accounting Standard No. 117, "Financial Statements of Not-for-Profit Organizations" (FAS #117). Paragraph 23 of FAS #117 indicates that organizations are free to classify activities as either "operating" or "nonoperating" in the statement of activities. The only requirements of FAS #117 with respect to reporting on "operating" activities are that the organization's operating indicator be clearly defined in the financial statement footnotes and that the net change in unrestricted net assets be included in the statement.

The Exposure Draft does not appear to provide the same degree of flexibility in its limited discussion of the statement of operations. Chapter 10 of the Exposure Draft, "Revenues, Expenses, Gains, and Losses," discusses the need to define "operations" in the financial statement footnotes but does not adequately discuss the flexibility offered by FAS #117. The illustrative examples of statements of operations included in the appendix are too similar in form to convey the permitted flexibility.

Perhaps a paragraph should be added to the "Financial Statement Presentation" section of Chapter 10 of the Exposure Draft. This paragraph should address the flexibility allowed by FAS #117 in designing a statement of operations that meets the needs of each organization. I believe a clear discussion of this issue in the new audit guide would ease the transition from the old financial statement formats to the new formats required by FAS #117.

I appreciate your attention to these items. If there are any questions on my comments, please contact me at (717)-367-1121, extension 33318.

Sincerely,

Jeffry W. Tucker, CPA
Controller

c: W. Prazenica

jwt

The St. Joseph Healthcare System
FINANCIAL CENTER
2400 Louisiana Blvd. NE
Bldg 5 Suite 300
Albuquerque, New Mexico 87110

August 10, 1995

Annette Schumacher
Federal Government Division
A.I.C.P.A.
1455 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

Dear Ms. Schumacher,

I am the reimbursement manager for the St. Joseph Healthcare System in Albuquerque, New Mexico (U.S.A.). I am writing to you to comment on the AICPA Health Care Audit Guide exposure draft. More specifically, I wish to dissuade you from requiring disclosure of the "difference between third-party settlement estimates and actual (or revisions thereto)". I think this area is one with too many unknowns to make it worthwhile or meaningful to require disclosure of differences in settlement estimates. One reason why I think this is not good is: who knows when a settlement is really a settlement? There are countless cost reports with issues before the Provider Reimbursement Review Board (PRRB) or the Courts. Those settlements were made by HCFA and the provider did not agree with one or more (usually material) issues. This process usually takes three years and longer to be heard and if the matter is appealed, the conclusion of the matter can be in excess of a decade. What estimate would you compare to?

As the year progresses and I gain more information about my providers' numbers, I change my estimates in mid stream. Once the year is completed and I have information regarding the entire year, I again may modify (change) my estimate. After I get the cost reports prepared, I then know how much my company is owed or owes and that amount is never the same amount as my estimate. Even then, I must have some estimate for the effect of the subsequent Medicare audit. By the time the audit comes (usually a year or more later) I may have cause to revise my estimate again. This is especially the case whenever the reimbursement rules change, or more likely whenever the intermediary changes its interpretation of the rules or changes its approach to certain issue(s) which are present in my cost reports.

Another real life problem is that some intermediaries aren't very good, like New Mexico Blue Cross and Blue Shield. Poor audits by the intermediary may leave the provider in the position of possibly having to repay additional monies due to revised settlements as HCFA rejects the intermediary's performance. For four providers in Albuquerque, I have at least 27 reopening issues (these all result in revised settlements) that reach back to our June 30, 1989 reports. Nearly all of these reopening issues are

quality problems in the performance of the intermediary's job. Moreover, my Medicare reports for 1993 and 1994 are unaudited while my Medicaid reports are unaudited all the way back to 1991.

The next problem with reporting the difference between my estimates and whatever "actual" is has to do with the nature of my estimates of third-party settlements. For obvious reasons (I don't want to get surprised and fired) I estimate a range for each settlement. I have a low estimate and I have a high estimate. For the FYE 6/30/95, St. Joseph Healthcare System has $12,115,314 of Third Party Reserves. All but $650,000 of that amount is for cost report settlements. I have a range of $4,186,846 as a low and $12,942,013 as a high. The real number is most likely between. Whenever a settlement occurs, assuming it is accurate, what estimate would I compare to? The high? The low? Anywhere between? In addition, whenever a settlement occurs which I think is wrong and want to appeal, would I make a comparison of the (inaccurate) settlement to my estimate? What about the unsettled issue(s).

Due to the nature of these settlements, the problems associated with late or inaccurate settlements, the effect of having my estimate being a range of roughly $4 million to $12 million, I don't think we can give meaningful, accurate or useful information about differences between third party settlement estimates and actual. As far as revisions to my estimates, there are plenty of them and I cannot see what useful purpose there is in putting every revision I have in the annual financial statements.

Sincerely,

Bret Goebel, CPA
Reimbursement Manager
St. Joseph Healthcare System

The
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August 11, 1995

WILLIAM T. YOST
Director for Finance

Annette J. Schumacher
Technical Manager, File H-1-500
Federal Government Division, AICPA
1455 Pennsylvania Ave., NW
Washington, DC 20004-1081

Dear Annette Schumacher:

Thank you for the opportunity to comment on the proposed Audit and Accounting Guide.

The Kendal Corporation owns and/or operates five continuing care retirement communities. My comments concern Chapter 14 of the Guide.

Paragraph 14.23 states "unamortized deferred revenue from non-refundable fees should be recorded as revenue upon a resident's death or the termination of the contract."

This particular requirement contradicts the concept of actuarial pricing which is based upon revenues from the group being available to meet the costs incurred by the group. Type A communities in particular rely on some resident's dying early to provide funding for those who outlive their life expectancy. Since the adoption of SOP90-8, requiring this treatment I have noticed considerable volatility in the financial statements of CCRCs due to deferred revenue amortization. It is confusing to the residents, Boards and regulators.

I find that it is also inconsistent with paragraphs 14.28 and 14.29 where future costs and future revenues, including the unamortized deferred revenue, are evaluated on a group basis.

There is a practice of allocating the unamortized deferred revenue balance of deceased residents to all remaining residents. This is consistent with the underlying financial principles upon which the CCRC operates. I urge the Health Care Committee to allow for alternate treatments of death releases, such as the one previously mentioned.

I also request that the Committee change the annual requirement in 14.29 to a tri-annual requirement. Very little happens in a year or two to materially change the obligation. It is a costly and time-consuming activity. If a facility has made improvements to eliminate a previously recognized obligation, they could choose to recalculate it on a more frequent basis.

I appreciate your consideration of these requests.

Sincerely,

William T. Yost
Director for Finance

WTY/pgf

HARVARD UNIVERSITY

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August 8, 1995

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ED - Health Care Organizations

Chapter 14: Continuing Care Retirement Communities

Paragraphs 14.28 - 14.32 of the Exposure Draft assume that some CCRCs have contracts that restrict increases in fees. Few, if any, such CCRCs still exist; most have gone bankrupt. If a CCRC can increase its fees, the probability that it will have a net liability to provide future services is extremely small. If an actuarial calculation reports such a liability, it can be removed simply by increasing the assumed rate of fee increase. In order to be recognized as a liability, paragraph 35 of Concepts Statement No. 6 requires that the obligation be "probable."

The AICPA therefore should not require an actuarial calculation. It is an expensive exercise, necessarily based on assumptions that are much more iffy than the calculations required for pension plans. It an auditor finds, for whatever reason, that a CCRC probably cannot meet its current obligations, it is not a going concern, and should be so reported. Some states require an actuarial calculation, but this is not a reason to require it of everyone, especially not annually.

Paragraph 14.23 requires amortization of advance fees by the straight-line method. There are sound reasons for using a depreciation method in which the annual amount increases, that is, an annuity method. At most, the paragraph should require an amortization method that is "systematic and rational," which is the only GAAP requirement for depreciation. Actually, this point is adequately covered in other pronouncements relating to amortization; there is nothing unique about CCRCs.

Most of the other paragraphs in this chapter are descriptive, rather than prescriptive. The prescriptive sentences merely repeat the required practice for similar transactions in organizations generally. They also apply to certain condominium associations and cooperatives that are not Continuing Care Retirement Communities as this term is usually defined.

Only two other pages (Pages 86 and 87) in the Exposure Draft relate to a specific health care industry. There is no good reason to single out continuing care retirement communities for special treatment. I urge that Chapter 14 be deleted.

Sincerely,

RN Anthony

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August 8, 1995

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Not-for-Profit Organizations

This letter recommends alternative courses of action:

1. You should urge the Financial Accounting Standards Board to revise SFAS Nos. 116 and 117.

2. If you decide that you are not authorized to make such a recommendation, then you should combine your Exposure Draft with the Exposure Draft on Health Care Organizations.

3. In any event, you should make certain minor changes in the ED.

The first recommendation will require postponing the implementation date of SFAS No. 116 and 117, and the second probably will also require such a postponement. These postponements are eminently worthwhile. If not-for-profit organizations try to implement these Standards in the current fiscal year, many of them will be strongly critical. These criticisms can be avoided by the recommended actions.

1. Recommended Revision of SFAS Nos. 116 and 117

The Committee has done an excellent job in developing guides for the implementation of SFAS Nos. 116 and 117. At some point in their extensive deliberations, however, they probably asked themselves: will financial statements developed in accordance with this Guide provide more useful information than those now prepared by well managed nonprofit organizations? The answer is clearly, NO, it is not useful. There is therefore no point to your whole exercise.

Of the 100 pages in this document that are related to accounting (as distinguished from auditing), a substantial fraction is devoted to topics that have little or nothing to do with useful financial statements. They mostly have to do with the initial recording and the subsequent reclassification of transactions into the three novel "classes" (unrestricted, temporarily restricted, permanently restricted). Classification

of information in this way is not useful. Moreover, the document, and the companion Exposure Draft on Health Care Organizations, make it clear that not-for-profit organizations should report operating transactions separately from nonoperating transactions, even though such a separation is not required in SFAS No. 117, nor are the principles governing such a separation stated. These points are discussed below.

Advance Payments

In Chapters 5 and 6, the Committee wrestled with the problem of distinguishing between (1) advance payments that are contributions, and therefore reported as revenues in the temporarily restricted class in the period received, and (2) advance payments that are deferred revenues and therefore reported as liabilities; this problem is referred to in several places elsewhere in the ED. This classification is unimportant in the real world. As a practical matter, any legitimate organization that receives money in advance recognizes an obligation to do something in return. It does not make sense to record ANY advance payment as revenue in the period received. If this were done, the amount would be reported again as "support" in the period in which the specified work is done, and since "support" is a form of revenue, this is a clear case of double counting.

Trusts, Annuities, and Life Income Funds

Chapter 6 is an excellent description of the accounting that would be required for contributions made in the form of various types of trusts, annuities and life income funds. The appendix describes the complications involved in deciding which net asset class the contribution belong in initially and in moving the contribution and the related income from one class to another. The amounts that end up in each class are not useful information. All these complications are unnecessary; they would be avoided if organizations simply followed good current practice.

Contributed Art

Paragraphs 7.05 - 7.18 and Chapter 11 describe the convoluted entries that are required for contributed art objects under various circumstances. They result in fragmentation of information about collections of art, both contributed and purchased; art items would be reported in each of the three net asset classes. All these complications would be avoided and the financial statements would be much more informative if organizations followed good current practice; that is, if they reported contributed art as a nonoperating item.

Separation of Operating and Nonoperating Transactions

Paragraph 49 of Concepts Statement No. 4 states that "financial reporting must distinguish between resource flows that are related to operations and those that are not." Your Exposure Draft implies that such a separation is desirable, and the Exposure Draft on Health Care Organizations makes this point even more strongly; its sample financial statements contain such a separation. Such a separation is made currently in the financial statements of most not-for-profit organizations. An operating statement is important to outside users, to trustees, and to management.

Paragraph 23 of SFAS No. 117 permits but does not require, such a separation. It was added in the final draft because of the overwhelming criticism of its omission

from the Exposure Draft. However, the separation between operating and nonoperating items is given no more importance than classifying items as "expendable and nonexpendable, earned and unearned, recurring and nonrecurring, or in other ways."

In view of the importance of an operating statement, why didn't the FASB require one? Its stated reason was that "operating" is difficult to define. This is not a valid reason because (1) the FASB is supposed to decide on the best definition of important terms, and (2) an operating statement in a not-for-profit organization is essentially the same as an income statement in a business, and the principles governing such a statement are well established.

The real reason for the FASB's strange omission is that if an operating statement were required, the other items reported in the unrestricted class would be an uninformative mixture of plant, endowment, and other operating items. For example, if an organization reported endowment revenue according to the total return/ spending-rate method, it would report an additional amount of endowment income as nonoperating, unrestricted income; this is confusing and negates the basic reason for using the total return/spending-rate method. Such a presentation would demonstrate the foolishness of the three classes. It would demonstrate the need to revise Concepts Statement No. 6, which was the first exposition of these classes. The FASB does not want to make such a revision.

Even though SFAS No. 117 does not require an operating statement, most not-for-profit organizations will continue to prepare them; users will insist on them. However, without the guidance of an *Accounting Guide*, there will be no consistency in their preparation, and the resulting statements will be confusing and noncomparable. Your committee could not provide such a guidance because this would imply that such a statement is more important than SFAS No. 117 admits. (The 1986-88 AICPA task force on *Display in the Financial Statements of Not-for-Profit Organizations* faced the same issue, but that task force ducked it.)

A revision of SFAS No. 117 should specify the revenue and expense items that are reported in an operating statement and how the amounts of these items should be measured. It would be similar to the corresponding pronouncements in business enterprise accounting.

2. A Combined *Accounting Guide*

If the not-for-profit committees are unwilling to recommend a revision of Concepts Statement No. 6, then you should combine the two not-for-profit *Accounting Guides.* (I limit this analysis to accounting, but the same principles apply to the auditing material in these guides.)

One of the objectives of the FASB's work in the not-for-profit area is to eliminate, or at least reduce, the differences that now exist in the form and content of financial statements (SFAS No. 117, ¶2). Obviously, having two *Accounting Guides* is inconsistent with this objective. This causes confusion and extra effort to users who

analyze the financial statements of both health care organizations and other not-for-profit organizations, by students and their professors who are studying nonprofit accounting, and in certain cases by preparers of the statements. For example, a medical center includes a hospital and a medical school; financial statements for the whole entity cannot be prepared if different rules govern the accounting for these two components.

The two Exposure Drafts address the topics differently:

- Most topics in the two documents have the same substance but use different words. These differences reflect the personal preferences of the two committees, not differences in the nature of the transactions. An *Audit Guide* is published by the American Institute of Certified Public Accountants, not by a committee of that organization. If the AICPA publishes two *Audit Guides* that are not entirely consistent with one another, it gives a poor impression of its professional competence.

- The topics of "Contributions Received and Agency Transactions" (Chapter 5) and "Split-Interest Agreements" (Chapter 6) have 29 pages on these topics. Similar transactions occur in health-care organizations. Indeed, the development professionals in health-care organizations belong to the same professional association as those in other not-for-profit organizations, and their organization publishes some guidance as to how contributions should be recognized. However, these topics are given only a cursory treatment in the health-care ED.

- The health-care ED, has the following topics that are unique, in whole or in part to health care organizations: receivables, commitments and contingencies, prepaid health care, and continuing care retirement communities. As written, the material on these topics total 21 pages, including the portions that are also included in the ED on not-for-profit organizations. Adding these topics to the not-for-profit ED would not increase its length unduly.

- The health-care ED has a glossary, but the not-for-profit ED does not. Preferably, the combined ED should have a glossary.

- The health-care ED has 68 pages of illustrative financial statements; the not-for-profit ED has none. Illustrative statements are useful, but they do not have the status of an *Accounting Guide* because SFAS No. 117 quite properly permits flexibility of format within its general rules. These illustrative statements, and statements for other not-for-profit organizations, should be published in a separate booklet so as to indicate that they are illustrative, not prescriptive.

Issuance of a separate *Accounting Guide* on health-care organizations cannot be justified by the argument that they apply to both for-profit and nonprofit organizations. The same situation exists in other industries. There are more for-profit proprietary schools than there are nonprofit colleges and universities. There are for-profit cemetery organizations, libraries, museums, and performing arts organizations. All these organizations are specifically included in ¶1.03 of the *Not-For-Profit Accounting Guide.*

3. Specific Comments

The following points are relevant whether or not the approaches suggested above are adopted.

Depreciation

Paragraph 9.08 states that depreciation on contributed assets that were initially booked as temporarily restricted should be reported as unrestricted expense and that an amount should also be booked as unrestricted support (which is a form of revenue). The bold-face sentences in this paragraph state that the amount reported as unrestricted support need not be the same as the amount reported as depreciation. This would defeat the purpose of ¶16 of SFAS No. 116. This paragraph was intended to correct what would otherwise be an understatement of income if depreciation on contributed assets were reported, with no offsetting amount of revenue. To accomplish this objective, the debit amounts should be the same as the credit amounts.

Issue 2: Financial Aid

We are asked to comment on the treatment of financial aid. Actually, I doubt that the *Accounting Guide* can take a position on it; ¶23 of SFAS No. 117 permits an organization to classify items such as this in any way it wishes. In any event, I hope that the final draft does not require that financial aid be treated as a tuition discount. The consultant who originally proposed this treatment based her argument on the alleged analogy with sales discounts. Although there is some resemblance, the analogy with quality enhancement expense is more valid; that is, financial aid is an expense that is incurred in order to enroll the best student body. With this view, revenues include the total tuition charged, and financial aid is one of the associated expenses. Using the total revenue as 100%, colleges find it useful to report the percentages for various expense elements. This analysis would be distorted if reported revenue did not include the total tuition. I admit that we probably could get accustomed to the alternative, but I see no persuasive reason for changing current practice.

Sincerely,

TCN Anthony

cc: Health Care Committee

Hospital of Saint Raphael

A member of the Saint Raphael Healthcare System

1450 Chapel Street
New Haven, Connecticut 06511
(203) 789-3000

July 31, 1995

Ms. Annette J. Schumacher
Technical Manager File H-1-500
Federal Government Division
American Institute of Certified Public Accountants
1455 Pennsylvania Avenue NW
Washington, DC 20004-1081

Dear Ms. Schumacher:

Hospital of Saint Raphael, a 511-bed tertiary care teaching hospital located in an inner city neighborhood, appreciates the opportunity to respond to the exposure draft of the Health Care Organizations Proposed Audit and Accounting Guide.

Our compliments on the improved overall tone of the proposed Guide. Two significant elements of the improvements include:

- The recognition of the continued influence of managed care on healthcare organizations, with specific guidance given on accounting for capitation arrangements; these are realities of the healthcare industry today.

- The recognition that tax-exempt hospitals should be treated as businesses, since we compete in a marketplace with taxable hospitals; tax-exempt hospitals are not similar to, and should not be treated like, non-for-profit philanthropic or higher educational institutions.

We appreciate your services consideration of our comments, which are attached to this transmittal. If we can provide any further clarification on our comments, please do not hesitate to contact us.

Sincerely,

James R. Rude
Director of Finance

JRR/dap
attachment

RESPONSE - SPECIFIC ISSUES FOR COMMENT

ISSUE 1: EXPIRATIONS OF DONOR-IMPOSED RESTRICTIONS ON LONG-LIVED ASSETS

We believe that **the Guide should be more restrictive** for health care organizations.

While a restriction on cash donations can easily be tracked and monitored, and relieved once that cash asset has been transformed into a long-lived asset (such as plant and equipment), a restriction on the long-lived asset is much more difficult to follow.

Donors can impose meaningful restrictions on how cash is to be spent. However, donors usually are not capable of imposing meaningful for restrictions on how a long-lived asset is to be used. Technology changes can result in the earlier than planned obsolescence of plant and equipment, while lack of technological change and/or limited financial resources may result in an extension of the planned use of plant and equipment.

These factors are clearly operational in nature, and have nothing at all to do with donor restrictions. The real accounting and reporting and audit issues relate to the appropriate accounting for the long-lived asset, not the donor restriction.

ISSUE 2: ACCOUNTING FOR INVESTMENTS

We believe that changes in the valuation allowance related to debt and equity securities **should not be included above the operating income caption** in the statement of operations.

The issue here is a much larger issue, however. The overall premise of the Guide is that a not-for-profit healthcare organization is a business-oriented entity, not similar to a not-for-profit philanthropic organization. The Proposed Statement on Accounting for Certain Investments Held by Non-for-Profit Organizations focuses on the change in net assets not being "a performance measure equivalent to net income of a business enterprise" (paragraph 48 of Proposed Statement); this philosophy is in direct contrast to the business orientation noted in paragraph 1.2(b) of the Proposed Audit and Accounting Guide. Accordingly, we believe that the concept of marking investments to market is inappropriate for a non-for-profit healthcare entity.

The Proposed Statement refers to FASB Concepts Statement No. 1, Objectives of Financial Reporting by Business Enterprises, which supports the proposals for accounting by not-for-profits. However, since healthcare providers have a business orientation, we believe that healthcare providers should be treated as business enterprises and **should follow the rules of SFAS #115**, not the Proposed Statement's suggested treatment.

RESPONSE - COMMENTS ON PROPOSED AUDIT AND ACCOUNTING GUIDE

Paragraph 5.13 refers to a **statement of activities**; we strongly recommend always referring to the **statement of operations** to avoid confusion.

Paragraph 10.3 requires that premium revenues be segregated from patient service revenues; however, no guidance is given related to associated expenses. For example, in a truly capitated arrangement some of the PMPM fees are allocated to other providers, to reserves, and for reinsurance of risk. We strongly recommend that **guidance be given, and that there be significantly expanded disclosures of gross vs. net premiums, the level of reserves and reinsurance carried to cover catastrophic losses, and other related information.**

Paragraph 10.5 requires that items historically treated as non-operating revenues will be combined with other operating revenues; this inclusion will no longer allow for a reader of the financial statements to be able to segregate the financial health of the healthcare operations from other gain and loss activities. Accordingly, we strongly recommend that **non-operating revenues continue to be segregated from operating activities.**

Paragraph 10.7 refers to a **statement of activities**; see comment above for paragraph 5.13.

Sample not-for-profit Hospital Financial Statements; we strongly recommend that the example be **expanded to include PMPM revenues,** as hospitals will most likely have traditional and non-traditional revenue sources.

FITCH
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)ne State Street Plaza
lew York, NY 10004
212) 908-0500

August 11, 1995

Ms. Annette Schumacher
Technical Manager
File H-1-500
Federal Government Division of the AICPA
1455 Pennsylvania Avenue
Washington, D.C. 20004-1081

RE: Exposure Draft Proposed Audit and Accounting Guide for Providers of Health Care Services

Dear Ms. Schumacher:

As a analyst with the bond rating agency of Fitch Investors Service, I am involved in the rating of physician group practices. In recent years, these have evolved as an increasingly important and distinct segment of the health care provider industry.

I believe it would be important to include illustrative financial statements for physician group practices in the new audit and accounting guidelines. Among the issues to be addressed would be:

- IBNR reserves and risk pool arrangements
- payments to outside providers for services rendered under capitated contracts
- treatment of capitated payments to own physicians when the practice owns an HMO
- standardized presentation of "dean's tax" and contributions to medical school by academic physician group practices

With the increasing prevalence of capitated payment contracts and the assumption of full risk contracts by physicians, factors such as the above are critical in assessing the financial position of a physician group. Also, the industry itself recognizes the need for more standardization in how financial data is reported in order to allow comparisons between different physician groups.

Such standardized information is also important to employers, HMOs, and sources of financing seeking to analyze the comparative financial strength and creditworthiness of physician groups in making contracting or lending decisions.

I would be most happy to provide assistance drafting such guidelines.

Sincerely,

Pauline Clark

Pauline Clark
Director
Healthcare & Higher Education Group

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August 10, 1995

Ms. Annette J. Schumacher
Technical Manager
Federal Government Division AICPA, File H-1-500
1455 Pennsylvania Avenue, NW
Washington, D.C. 20004-1081

Dear Ms. Schumacher:

We are pleased to respond to the AICPA Health Care Committee's request for comment on the exposure draft: "Proposed Audit and Accounting Guide - Health Care Organizations" (the Proposed Guide). We support the issuance of the Proposed Guide, however, we have the following comments and suggestions for the Committee's consideration.

Exhibit - Specific Issues for Comment

Issue 1: Expirations of Donor-Imposed Restrictions on Long-Lived Assets

We believe the proposed restriction is appropriate for health care organizations.

Issue 2: Accounting for Investments

We strongly believe that the fair value approach should be adopted for investments held by health care organizations, however, we believe the change in valuation related to debt and equity securities should not be included in operating income; furthermore, we believe that realized income should not be included in operating income. This position is based on the following:

- Investment earnings are not directly related to providing health care or any other operating activities. Although we realize some entity's use earnings on investments for funding operations and for capital expenditures, we do not believe that this presents a true picture of the results of operations thus making it difficult to assess a health care organization's efficient and effective use of its resources. For example, assume that a health care organization generates $100,000 operating income in year one and invests this $100,000. In year two assume they have zero operating income, but they have earned $10,000 on their investment. If investment income were included as a

component of operating income, their statement of operations would indicate that they generated $10,000 from operations, when in fact, the income was not generated from operations;

- The change in valuation is related to market conditions thus creating volatility in operating results. Volatility in the market would skew operating indicators and make it difficult for investors (bondholders), analysts and rating agencies to determine true operating results;

- Volatility in the market creates events and circumstances which may be largely beyond the control of health care organizations and their management;

- Resulting income or loss from change in valuation does not have any relationship to the cost effectiveness of the facility; however it may be perceived to be related;

- Including investment earnings as a component of operating earnings weakens the importance and relevance of operating indicators; and

- Including investment earnings, both realized and unrealized, in operating income does not provide the reader with any meaningful information.

Further, Statement of Financial Accounting Concepts No. 6 Elements of Financial Statements defines the following:

> Revenue - Revenues are inflows or other enhancements of assets of an entity or settlements of its liabilities (or a combination of both) from delivering or producing goods, rendering services, or carrying out other activities that constitute the entity's ongoing major or central operations.
>
> Gains - Gains are increases in equity (net assets) from peripheral or incidental transactions of an entity and from all other transactions and other events and circumstances affecting the entity except those that result from revenues or investments by owners.

We believe that, based on the above definitions, investment earnings in a health care organization do not constitute the entity's ongoing major or central operations, but rather are related to peripheral or incidental transactions, and thus more appropriately represent gains, and, therefore, should not be included in operating income.

If it is deemed appropriate to include the change in valuation in operating income, perhaps it could be presented as "Operating income before investment earnings" and "Operating income after investment earnings."

Chapter 10 - Expenses

Section 10.17 states that, basically, expenses should be reported using a functional presentation either on the face of the financial statements or disclosed in the footnotes. We believe that the disclosure of functional expenses, whether it be on the face of the financial statements or in the notes, should not be required as it provides limited value, if any. Furthermore, we believe that the guidance to report functional expenses is very general and will lead to many inconsistencies because of differences in different health care organizations' interpretations of the classifications. These inconsistencies may be between unrelated health care organizations or even within the same health care organization, in either case, it will not promote comparability.

We appreciate the opportunity to provide our comments and suggestions on the Proposed Guide.

Very truly yours,

Sisters of Mercy Health System, St. Louis, Inc.

Healthcare Financial
Management Association

HFMA

1050 17th Street NW
Suite 700
Washington, DC 20036-5503
Telephone 202.296.2920

August 11, 1995

William R. Titera, Chair
Health Care Committee
c/o Annette Schumacher Barr, Technical Manager
American Institute of Certified Public Accountants
1455 Pennsylvania Avenue, NW
Washington, DC 20004-1081

Re: File H-1-500, Federal Government Division
Exposure Draft, Proposed Audit and Accounting Guide,
Health Care Organizations

Dear Mr. Titera:

The Healthcare Financial Management Association (HFMA) appreciates this opportunity to comment on the proposed audit and accounting guide for health care organizations of the American Institute of Certified Public Accountants (AICPA). This proposed audit and accounting guide (the Guide) would significantly change healthcare financial reporting.

HFMA is a professional membership organization of almost 33,000 individuals involved in various aspects of healthcare financial management. In 1975, HFMA recognized the need to establish a special group of expert members within HFMA to serve as the primary advisory group in the areas of accounting principles and financial reporting practices. This group, HFMA's Principles and Practices Board, was consulted in the development of this comment letter.

The evolution of the healthcare industry is resulting in integrated health networks of for-profit, not-for-profit, and governmental healthcare organizations. As of 1993, national health expenditures represented 13.9 percent of our gross domestic product. Consistency and comparability in financial reporting for such a significant industry should be paramount to FASB, GASB, and the AICPA. The Guide attempts to create consistency and comparability for an industry that must conform to divergent accounting principles and financial reporting standards.

Statement of Operations

HFMA agrees that the healthcare industry is in need of an operating indicator in the statement of operations. **HFMA also strongly believes** that the flexibility in

presentation given to for-profits should be given to not-for-profits. Not-for-profit entities should be allowed to distinguish between operating activities and other income and expenses unrelated to operations, in the same manner as for-profit entities. These other income and expenses should be reflected below the operating indicator in the statement of operations. However, the term "non-operating," which is unique to not-for-profit entities, should be eliminated. **HFMA prefers** the term "other income (expense)," which is commonly used by for-profit entities.

HFMA believes that revenue and expenses reflected below the operating indicator as "other income (expense)" should include all items not directly related to the mission of the organization. For example, insurance companies and HMOs commonly report all investment income in operations, since investment income is a key component of the rate setting and actuarial estimation process for these organizations. The Guide should not create restrictions for not-for-profits, nor inconsistencies with for-profit reporting.

HFMA believes that the Guide should continue to allow flexibility in reporting investment income and contributions. The operating indicator should reflect those activities integral to financial planning and directly related to the mission of the organization. Therefore, different types of healthcare organizations will report investment income and contributions consistently based on their common structures, objectives, and missions.

HFMA believes that a subtotal for "income from operations" should be included in all statements of operations and that additional formats should be included in the illustrative financial statements in the final audit guide. Enclosed are sample statements of operations to demonstrate several alternate formats resulting from the recommended flexibility in presentation. HFMA noted that paragraph 10.14 in the Guide allows flexibility in reporting, and believes that the illustrative financial statements in the Guide should also reflect this flexibility.

Board-Designated Assets

HFMA believes that the Guide should conform to Accounting Research Bulletin (ARB) No. 43, which allows a clear distinction in reporting investments based on the purpose and intended use of funds, as follows:

> "This concept of the nature of current assets contemplates the exclusion from that classification of such resources as: (a) cash and claims to cash which are restricted as to withdrawal of use for other than current operations, are designated for expenditure in the acquisition or construction of noncurrent assets, or are segregated for the liquidation of long-term debts..." [Chapter 3, Section A, Paragraph 6]

HFMA believes that the Guide should not eliminate reporting of internal restrictions such as board-designated assets from the balance sheet. ARB No. 43 clearly allows for the exclusion from current assets of internally restricted assets if designated by the board for equipment, building, construction, and debt retirement. If an investment portfolio is not designated for other than current operations, then the investment classification should be based on the nature of the underlying instruments, liquidity being a key measure. The nature of the intended use of investments should be disclosed in the footnotes of the financial statements. **HFMA believes** that due to the capital-intensive nature of the healthcare industry, the elimination of the board-designated assets classification could mislead users of the financial statements regarding the intent to use assets to liquidate current liabilities.

Investments

In a June 29, 1995, comment letter (copy attached), HFMA strongly urged FASB to exclude healthcare organizations from the scope of its exposure draft, *Accounting for Certain Investments Held by Not-for-Profit Organizations*, and to make FASB Statement No. 115 applicable to all healthcare organizations. If fair value is adopted for the healthcare industry, **HFMA recommends** that unrealized gains and losses should follow the reporting of the related realized gains and losses. Paragraph 4.13 of the Guide should be changed to reflect this.

Effective Date

HFMA recommends that the effective date for the Guide be delayed to an appropriate date **after** the final Guide is issued. FASB Statements 116 and 117 have effective dates for fiscal years beginning after December 15, 1994, FASB's exposure draft on not-for-profit investments has a proposed effective date for fiscal years beginning after December 15, 1995, and the Guide has a proposed effective date for fiscal years beginning after June 15, 1995. The

Guide's conclusions on consolidations could change the reporting entity. Therefore, the Guide cannot be practically implemented prior to the end of the comment period due to problems with reporting for interim periods, such as stub period reporting for bond issues.

Donor-Imposed Restrictions on Long-Lived Assets

HFMA recommends that healthcare entities be allowed the flexibility of reporting the expiration of donor-imposed restrictions on long-lived assets per FASB Statement 116. The two options allowed under FASB Statement 116 are (1) recognition when the asset is placed in service and (2) recognition over the useful life of the asset. Paragraph 10.9 of the Guide should be changed to allow the option for recognition over the useful life of the asset.

Claims-Made Policy Accounting

HFMA also recommends that accounting for claims-made insurance policies and tail coverage, in Chapter 8 of the Guide, should be evaluated by the AICPA based on current practices in the industry.

Not-for-Profit Audit Guide

HFMA recommends that the health care audit guide either incorporate the language from certain sections of the not-for-profit audit guide or refer readers to those sections of the not-for-profit audit guide. The relevant sections of the proposed not-for-profit audit guide address contributions received, agency transactions, split-interest agreements, and endowment funds, which are tangentially applicable to health care. These are not covered as comprehensively in the proposed health care audit guide.

Inconsistencies Among Audit Guides

HFMA believes that FASB Statement No. 115 should be made applicable to all organizations covered by the health care audit guide. **HFMA recommends** that the following provision from the not-for-profit audit guide be included in the health care audit guide in order to accomplish that objective. The exposure draft of the not-for-profit audit guide states the following:

> "Not-for-profit organizations are exempt from the scope of certain FASB and other pronouncements. Organizations that do not meet the FASB Statement No. 117 definition of a not-for-profit organization, regardless of whether they are within the scope of this Guide, are not not-for-profit organizations and

> are required to follow generally accepted accounting principles (GAAP) applicable to for-profit entities." [Paragraph 1.04]

The key elements of the definition of "not-for-profit organizations" in FASB Statement No. 117 are (a) receipt of significant amounts of contributions, (b) operating purposes other than to provide goods or services at a profit, and (c) absence of ownership interests like those of business enterprises. The distinctive issue is the receipt of significant amounts of contributions, as not-for-profits by definition meet the criteria in (b) and (c).

Although some healthcare organizations receive significant amounts of contributions, most do not. If the provision in the not-for-profit audit guide were included in the health care audit guide, most "not-for-profit" healthcare organizations would be required to follow FASB Statement No. 115.

Thank you for the opportunity to comment. We welcome the opportunity to meet with you, or members of the AICPA, to discuss this matter. Should you have any questions, please call Patty Hlavinka, FHFMA, CPA, Policy Analyst, at (202) 296-2920.

Sincerely,

Richard L. Clarke, FHFMA
President

Enclosures
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Sample Not-for-Profit Hospital **Format A**
Statement of Operations
Years Ending December 31, 19X7 and 19X6
(in thousands)

	19X7	19X6
Unrestricted revenues, gains and other support:		
Net patient service revenue	$ 95,156	$ 88,942
Other, Primarily interest income	7,951	9,562
Net assets released from restrictions	500	
Total revenues, gains and other support	103,607	98,504
Expenses and losses:		
Operating expenses	90,521	81,885
Depreciation and amortization	4,782	4,280
Interest	1,752	1,825
Provision for bad debts	1,000	1,300
Total expenses	98,055	89,290
Operating income	5,552	9,214
Contributions of long-lived assets	235	485
Transfers to parent	(640)	(3,000)
Increase in unrestricted net assets, before extraordinary item	5,147	6,699
Extraordinary loss from early extinguishment of debt	(500)	
Increase in unrestricted net assets	$ 4,647	$ 6,699

See accompanying notes to financial statements.

Sample Not-for-Profit Hospital **Format B**
Statement of Operations
Years Ending December 31, 19X7 and 19X6
(in thousands)

	19X7	19X6
Unrestricted revenues:		
Net patient service revenue	$ 95,156	$ 88,942
Net assets released from restrictions	500	
Total unrestricted revenues	95,656	88,942
Expenses:		
Operating expenses	90,521	81,885
Depreciation and amortization	4,782	4,280
Interest	1,752	1,825
Provision for bad debts	1,000	1,300
Total expenses	98,055	89,290
Operating income (loss)	(2,399)	(348)
Other income:		
Interest income	7,451	9,062
Contributions	500	500
Total other income	7,951	9,562
Net income	5,552	9,214
Contributions of long-lived assets	235	485
Transfers to parent	(640)	(3,000)
Increase in unrestricted net assets, before extraordinary item	5,147	6,699
Extraordinary loss from early extinguishment of debt	(500)	
Increase in unrestricted net assets	$ 4,647	$ 6,699

See accompanying notes to financial statements.

Sample Not-for-Profit Hospital
Statement of Operations
Years Ending December 31, 19X7 and 19X6
(in thousands)

	19X7	19X6
Unrestricted revenues:		
Net patient service revenue	$ 95,156	$ 88,942
Net assets released from restrictions	500	
Total unrestricted revenues	95,656	88,942
Expenses:		
Operating expenses	90,521	81,885
Depreciation and amortization	4,782	4,280
Provision for bad debts	1,000	1,300
Total expenses	96,303	87,465
Operating income (loss)	(647)	1,477
Other income (expenses):		
Interest income	7,451	9,062
Contributions	500	500
Interest expense	(1,752)	(1,825)
Total other income (expenses)	6,199	7,737
Net income	5,552	9,214
Contributions of long-lived assets	235	485
Transfers to parent	(640)	(3,000)
Increase in unrestricted net assets, before extraordinary item	5,147	6,699
Extraordinary loss from early extinguishment of debt	(500)	
Increase in unrestricted net assets	$ 4,647	$ 6,699

See accompanying notes to financial statements.

Healthcare Financial
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June 29, 1995

Dennis R. Beresford, Chairman
Financial Accounting Standards Board
401 Merritt 7
P.O. Box 5116
Norwalk, CT 06856-5116

Re: Exposure Draft, *Accounting for Certain Investments Held by Not-for-Profit Organizations*

Dear Mr. Beresford:

The Healthcare Financial Management Association (HFMA) appreciates this opportunity to comment on the exposure draft of the proposed statement of the Financial Accounting Standards Board, *Accounting for Certain Investments Held by Not-for-Profit Organizations* (ED). This proposed statement would move not-for-profit healthcare organizations' investment valuation method from the lower-of-cost-or-market to fair value.

HFMA is a professional membership organization of almost 33,000 individuals involved in various aspects of healthcare financial management. In 1975, HFMA recognized the need to establish a special group of expert members within HFMA to serve as the primary advisory group in the areas of accounting principles and financial reporting practices. This group, HFMA's Principles and Practices Board, was consulted in the development of this comment letter.

Applicable to all healthcare organizations

The evolution of the healthcare industry is resulting in the integration of for-profit, not-for-profit, and governmental healthcare organizations. Many of these organizations, under FASB's control definition in its preliminary views on consolidation, will be required to consolidate. If investment valuation methods differ for for-profit and not-for-profit healthcare organizations, unnecessary complexity and extensive additional disclosures will be created. Furthermore, the users of financial statements are best served when meaningful comparisons and analysis among industry constituents can be made.

Adoption of three categories of investments

In paragraph 48 of the ED, FASB sets forth its reasons for not adopting the three categories of investments in SFAS No. 115. This paragraph states that these categories "are less relevant for not-for-profit organizations because the change in net assets is not a performance measure equivalent to net income of a business enterprise." It has already been acknowledged, and HFMA agrees, that as set forth in the Guide, the healthcare industry requires an operating indicator reflecting net income similar to business enterprises. **Therefore, HFMA believes that it is extremely relevant that the healthcare industry, as a whole, conforms to SFAS No. 115 and adopts the three categories of investments.**

Changes in value of available-for-sale securities

Since the healthcare industry reports an operating indicator similar to business enterprises, it is also important to reiterate and emphasize the discussion in paragraph 49 of the ED. The healthcare industry distinguishes between components of comprehensive income, reporting certain changes in net assets in its operating indicator, and other changes in net assets below the operating indicator. Therefore, the distinction between trading securities and available-for-sale securities is relevant for the healthcare industry in reporting changes in fair value. **HFMA believes that healthcare organizations should report the changes in value of available-for-sale securities, resulting from the implementation of SFAS No. 115, as other changes in net assets below the operating indicator in the Statement of Operations.**

Importance of held-to-maturity classification

Healthcare organizations commonly invest in debt securities, whether the organization is for-profit or not-for-profit, and many of these investments are held-to-maturity. These investments commonly provide funding for the scheduled replacement of property, plant, and equipment of the facility, as well as required reserves for long-term debt. The fair value of these debt instruments is affected, primarily, by fluctuations in interest rates. Reporting of a change in fair value due to a change in interest rates for a held-to-maturity debt instrument is not consistent with the ultimate outcome of

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HEALTH SYSTEM
WEST

August 11, 1995

Annette J. Schumacher, Technical Manager
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Re: Proposed Audit and Accounting Guide--Health Care Organizations

Dear Ms. Schumacher,

We are pleased to submit the following comments on the Proposed Audit and Accounting Guide--Health Care Organizations.

Expirations of donor-imposed restrictions on long-lived assets (Issue #1). We agree that this restriction is appropriate for health care organizations.

Accounting for investments (Issue #2). If the FASB adopts a fair value approach, we believe that changes in the valuation allowance should **not** be included above the operating income caption due to possible distortions of operations (particularly for debt instruments to be held to maturity). However, we strongly believe that a far better solution would be for the FASB to make the provisions of FAS115 applicable to not-for-profit organizations.

Board-designated assets are not included in the list of types of assets to include under the caption Assets Whose Use Is Limited in paragraph 3.1. If it is indeed the Committee's intent to exclude them (as we agree they should be), we believe the Guide should specifically state this to avoid any possible confusion over what has been a long-standing industry practice.

Agency funds. We believe that further guidance would be helpful as to exactly what constitutes agency funds that require recognition in the financial statements. Is there one or more key criteria that determine this? In the example given in paragraph 3.2, would it make a difference which entity's name the bank accounts were in? (We would suggest that it does.)

Uncollectible pledges. We believe that FAS 116, paragraphs 19 and 20 implies that there is no such thing as bad debt expense related to support recognized from a pledge, i.e. the estimated amount of uncollectible pledge support is netted directly against support rather than grossed up in support and bad debt expense. If our interpretation is correct, we believe it would be helpful to explicitly state this in the Guide. This is particularly important in paragraph 5.14 since we believe the first sentence there could be interpreted to mean that a discount rate is to be applied to the gross amount of pledges receivable (because of the phrase "commensurate with the risks") rather than the net amount after uncollectibles. A discount rate should only be applied to measure the time-value of money, not as a means to value the collectibility of a receivable. We believe this sentence should be modified and expanded upon to make this concept more clear.

Prepaid physician services. We believe it would be helpful if paragraph 6.3 would further indicate what constitutes a prepaid expense versus a notes receivable from a physician. For example, if a hospital pays a physician a guaranteed amount of money simply for meeting the community's need of a physician and staying in the area for a stated period of time, would that alone constitute a prepaid expense? Or, would the physician be required to provide the hospital with documentation of uncompensated care he/she provided?

Contributions of long-lived assets. We believe that Contributions of long-lived assets should not be **required** to be excluded from operations, as apparently indicated in paragraph 10.13. In fact, we believe that inclusion in operations is **preferable,** and the Guide should encourage such practice, for the following reasons: (1) FAS 116 clearly changed the reporting of contributions of long-lived assets from an equity transaction to an income transaction (to be included in *unrestricted support*) no different (we believe) than any other type of contribution. We don't believe it is meaningful to make such a marked distinction between contributions simply because of the type of asset contributed or to be purchased with the funds contributed. (2) For consistency with how *restricted* contributions of long-lived assets are eventually classified in the Statement of Operations--i.e. as operating items in the line "Net assets released from restrictions". (Note that paragraph 10.7 makes no differentiation in classification between restricted and unrestricted contributions of long-lived assets.) (3) We believe it is likely that many hospitals would consider such contributions, especially from its related Foundation as shown in the exhibit, as **not** being a peripheral or incidental transaction (to use terminology from the old Guide).

Index. If an index was not planned for the final Guide, we believe that including one would be very beneficial.

Note regarding our following three comments on the illustrative examples in the appendixes: Although the exhibits are just for illustrative purposes rather than required formats, we believe the examples have a strong influence on practice, and therefore the best approach (if there is a best approach) or otherwise the most common approach should be illustrated to encourage uniformity in reporting.

Premium revenue and resident service revenue. Since these are new financial statement lines introduced in this Guide, we believe the Statement of Operations exhibit on page 104 should show an example of how they may be displayed.

Operating expenses. We believe the use of the line "Operating expenses" on the Statement of Operations exhibit on page 104 is undesirable, and should be broken down by natural classifications (such as Employee compensation, Professional fees, Supplies, and Purchased services) as in the other exhibits. We believe that more detail on such a material figure is useful to readers of the financial statements, and that use of the term "operating expenses" for one expense category suggests that the other expense categories are **not** operating expenses. We recognize the usefulness of showing alternative formats in the various exhibits, but we would suggest that showing expenses on a functional basis (preferably in one of the other exhibits) may be a more appropriate format than the one shown here.

"Increase in long-term debt" line. We suggest re-wording the line "Increase in long-term debt" on the Statement of Cash Flow exhibit on page 106 to "Proceeds from issuing long-term debt", since the former wording is normally used to report a *net* increase.

Note: The following two comments may not be applicable if the FASB develops different guidance on accounting for investments before issuance of the Guide.

Debt securities. The Guide is not necessarily clear as to how to report a debt security for which there has been a temporary impairment of value. The first sentence in paragraph 4.2.a. appears to indicate that all debt securities are reported at amortized costs. However the second sentence appears to indicate that all (debt and equity) securities are reported at LCM if there has been a temporary impairment of value. For a debt security for which there has been an impairment of value, does the amortized cost criteria or the LCM criteria take precedence? (We believe that the answer (LCM) can be indirectly determined in the AICPA Professional Standards, AU sec, 9332, but that the wording in the Guide should be changed to make this clear.)

Changes in market values of marketable securities. Paragraph 10.5 and the exhibit on page 106, by inclusion of the word *realized*, could be interpreted to be excluding *unrealized* changes in market values of marketable securities from the given category heading. We believe that inclusion of certain unrealized changes in market values (as described in paragraph 4.13) should be added to the list in paragraph 10.5, and that the word realized should be removed from the exhibit on page 106 (because in most situations unrealized changes would be included in the Statement of Cash Flows), to make it clear that the word *realized* is not being used as a qualifier in these instances.

Thank you for considering our views on this.

Sincerely,

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Audit Supervisor

Cheryl Curry

Cheryl Curry, CPA
Director of Audit Services

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August 2, 1995

Ms. Annette J. Schumacher
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Re: AICPA Audit and Accounting Guide, Health Care Organizations (ED)

Dear Ms. Schumacher:

Proposed changes in the AICPA Audit and Accounting Guide for Health Care Organizations (ED) raise some very serious concerns about the impact on Yale-New Haven Hospital and the hospital industry in general. Of primary concern is the elimination of a non-operating revenue classification which would force all revenues to flow through operations and the classification of assets designated for plant expansion/improvement as current assets distorting true organizational performance.

The following specific comments are submitted based on Yale-New Haven Hospital's review of the impact of the proposed changes:

1. FAS No. 117 and ED provide that the statement of operations for not-for-profit enterprises reports all changes in unrestricted net assets for the period. However, the AICPA ED does not allow the same flexibility in reporting the results of operations as FAS No. 117 (i.e., the elimination of a non operating revenue classification).

   It is difficult to understand how the AICPA Health Care Committee came to its conclusion on the statement of operations when the Securities and Exchange Commission (the "SEC") allows for a non-operating income classification. In addition, the proposed FAS on Accounting for Certain Investments Held by Not-for-Profit Organizations provides a significant additional reason for not requiring all items to be included in the determination of income from operations. We strongly encourage the AICPA to adopt a position similar to FAS No. 117.

   Also, under the ED, assets designated for plant expansion/improvement (board designated) must be classified as current assets under cash and cash equivalents. This reclassification will distort an organizations key business ratios and again is more restrictive than FAS 117.

2. Although the comment period for the provisions included in FAS No. 117 relative to the treatment of investments has past, we would like to voice our opinion that the boards of not-for-profit hospitals have taken their fiduciary responsibility seriously and have made strides to grow and maintain the corpus of the endowment funds.

   We find the provisions of FAS No. 117, which require realized gains to be added to unrestricted net assets and not permanently restricted net assets, to be in conflict with a board's fiduciary responsibility. For many years, boards have established spending limits and reinvested amounts in excess of

spending limits as corpus of the endowment fund. Reporting realized gains as part of unrestricted net assets is contrary to the concept of maintaining the corpus of the endowment funds and could have a negative impact on future fund raising activities.

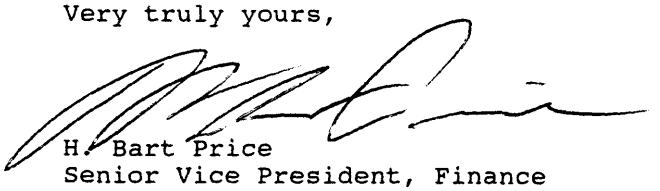
We recommend that the AICPA Guide rectify this situation by allowing for the classification of investment activity, including endowment fund related, based on the good-faith determinations made by an institution's governing board, and with appropriate financial statement disclosures of board policy.

3. As to the "new required disclosures", we suggest that it be noted that they are applicable only "if material". In addition, differences between original estimates of third party settlements and final settlements are customary; consequently, when is disclosure required? Also, it is interesting that the AICPA Health Care Committee would adopt this position when for profit enterprises are not required to make similar disclosures for income tax related differences.

4. It is our understanding that FASB and AICPA Not-for-Profit Committee are considering additional technical guidance on the "Agency - Variance Power" issue. We do not believe that additional guidance is necessary and the issue should be decided on an individual situation "facts and circumstances" basis.

Your consideration of our position on these issues and appropriate changes to the final version of the AICPA Audit and Accounting Guide, Health Care Organizations will be greatly appreciated.

Very truly yours,



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Proposed Audit and Accounting Guide - Healthcare Organizations

Dear Ms. Schumacher:

The Auditing and Accounting Standards Committee (the "Committee") of the New Jersey Society of Certified Public Accountants ("NJSCPA") is pleased to submit its comments on the proposed Audit and Accounting Guide - Healthcare Organizations. The views expressed in this letter represent the view of the members of the committee and are not necessarily indicative of the full membership of the NJSCPA.

The Committee has numerous concerns on the adoption of the proposed Audit and Accounting Guide - Healthcare Organizations.

The following is a summary of the Committee's concerns:

1. In response to the request of specific comment on Issue 1 - Expirations of donor imposed restrictions on long lived assets and Issue 2 - Accounting for Investments.

   The proposed audit guide eliminates the option of recognizing the expiration of donor-imposed restrictions over the life of the long-lived assets. The guide requires recognition of the expiration of the donor-imposed restriction when the asset is place into service. This treatment is problematic for the distortion of revenue in the statement of operations for a "capital type" transaction. Since the transfer out of Temporary Restricted is shown as

a transfer, the other side of the entry should be a "transfer in" and not reported as revenue in the Statement of Operations. Transfers from Temporary Restricted funds should be segregated into two basic types: those that apply to operating expenses or charity care and those that are for long live assets.

Transfers that relate to charity care or operating expenses should be included in the unrestricted revenues, gains and other support caption which is reflected in operating income, while donations of long lived assets should be classified below the operating income classification or reflected in the statement of changes in net assets.

The proposed audit guide also would require most changes in valuation allowances for marketable equity securities portfolios to be included in the operating income caption of the Statement of Operations. Until the new accounting literature is finalized for not-for-profits on accounting for investments, the treatment of unrealized gains and losses on investments for not-for-profits should be displayed as a change to net assets for all funds in the Statement of Changes in Net Assets. An alternative approach to both of these issues, would be to combine the Statements of Operations and Changes in Net Assets back together as displayed in FASB 117.

2. Please clarify (Chapters 3 and 4 of the proposed audit guide) whether investments in marketable securities and debt securities should all be combined based on "like type" of security rather than the intent of the entity to hold. Further, should investments in temporarily and permanently restricted funds, externally restricted funds held by a trustee for debt or self insurance , and investments held for other than operations, all be grouped into "like type" of investments and accordingly classified as current for all investments other than investments in long term bonds?

3. We feel reconsideration should be made for allowing the classification of non-operaiting gains and losses, which

would be consistently applied and disclosed (Chapter 10 of the proposed guide). This reporting classification provides meaningful information to the reader of the financial statements. Further, FASB 117 does not specifically prohibit the use of a non-operaing classification.

4. Chapter 8 of the proposed audit guide should contain more detail guidance on adopting SOP 94-6 "Disclosure of Certain Significant Risks and Uncertainties". For example, should pending funding cuts for Medicare and Medicaid be disclosed as a significant risk and uncertainty? The sample financial statements should include an illustrative example of the recommended disclosure.

5. Please clarify in Chapter 11 of the meaning of "the entity has control over another not-for-profit entity or has an economic interest in the other but not both" of the proposed audit guide. This description of control is confusing and needs to be clarified by examples.

6. Chapter 10 needs to be expanded to discuss gifts for the Hospital donated to a related Foundation. Please clarify the accounting treatments of a contribution for a Hospital made by a donor to a related foundation (non parent). Should "agency" accounting be followed? Please provide guidance on the accounting for revenue recognition of the gift.

7. In order to facilitate consistent applicable of adoption of FASB 116 and 117, the effective date of the proposed guide must coincide with the effective dates of FASB 116 and 117. Please provide guidance on how FASB 116 and 117 would be adopted if the audit guide is not effective until a year later?

8. Lastly, we feel that many of our concerns on the proposed Audit Guide are a result of FASB 117. The healthcare industry has more characteristics in common with the operations of "Corporate America" and less with other not-for-profit agencies. Accordingly, a host of problems arise from removing the traditional "bottom line" indicator and measurement of current years operations. Does operating

income now equate to revenue and gains in excess of expenses and losses? Users of the financial statements, such as Bond Holders, Boards of Trustees, and State regulators all rely on and monitor "bottom line operations". The proposed Statement of Operations is combining income from operations with changes in net assets and the results are a confusing presentation to the users of healthcare financial statements. We have received overwhelming negative responses from Hospital Boards, management, and other financial statement users to the format of the Statement of Operations. We urge that the Statement of Operations report results of operations as close to, if not identified with, the audit guide currently in use. Further, if the Statement of Operations cannot be modified, then we would suggest re-combining the Statement of Changes in Net Assets as displayed in FASB 117.

We appreciate your consideration of our comments. If you would like clarification on any of the points addressed in this comment letter, please do not hesitate to call.

Sincerely,

Michael P. Breslin

Michael P. Breslin
Chairman

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August 10, 1995

Annette J. Schumacher
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Dear Annette

Comments on the "Proposed Audit and Accounting Guide: Health Care Organizations" were submitted in a July 17, 1995 letter. I would like to expand on the first point of that letter concerning classes of organizations.

The healthcare audit guide tries to establish a single, coordinated set of rules for healthcare providers of all ownership types: investor-owned, governmental, and other not-for-profit. This focus on consistency is admirable and appreciated. FASB and GASB rules that are applicable to some organizations but not to others are creating an almost insurmountable challenge for AICPA however.

The proposed audit guide for not-for-profit audit organizations acknowledges the confusion caused by these selectively applicable rules. The problem may be just as severe for healthcare providers but is not acknowledged by the healthcare audit guide.

The not-for-profit guide points out that some not-for-profit organizations are within the scope of SFAS No. 117 and others are not. SFAS No. 117 applies to not-for-profit organizations that have three characteristics: 1) receipt of "significant amounts" of contributions 2) an operating purpose "other than to provide goods or services at a profit," and 3) an "absence of ownership interests..." It can be argued that healthcare providers do not meet any of these criteria; contributions are important but usually not significant, the need for a profit on services provided is usually acknowledged, and healthcare ownership interest changes hands frequently like any other business. FASB connects the three criteria that define a not-for-profit organization with the word <u>and</u> indicating that all three criteria must be present for the organization to be covered by the provisions of SFAS No. 117.

Healthcare providers that do not meet the SFAS No. 117 definition are not required to report expenses by function and are required to follow investor-owned organization rules for valuing investments. Both of these results of <u>not</u> meeting the SFAS No. 117 definition are probably consistent with the preferences of

most healthcare providers. However, if AICPA adopts their audit guide as drafted, all healthcare providers will be required to classify expenses by function and will probably have inconsistent rules to follow with respect to valuing investments.

It would be preferable for FASB and GASB to coordinate their efforts and to issue consistent rules for the same transactions by all types of entities. Until that happens, AICPA's commendable efforts to achieve consistency will probably be fruitless. None the less, the audit guide should:

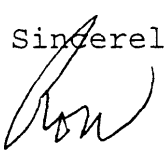
1. Acknowledge that not all healthcare providers are covered by requirements of SFAS No. 117. Provide clear guidelines to identify which are and which are not. Simply reiterating FASB's obscure criteria is not sufficient. Those criteria must be applied very specifically to healthcare providers. It is appropriate to point out that very few providers are included in the scope of SFAS No. 117.

2. Exclude provides that are not in the scope of SFAS No. 117 from the requirement to classify expenses by function. The illustrative financial statements will hardly need to be changed, retaining natural classification of expenses on the face of the statement and including a minimal discussion of expenses by functional classification in the note with mention as to the limited number of providers that will need to provide functional expense information.

3. Removing all guidelines concerning investments until FASB has released rules and then re-expose that chapter of the guide for insertion in the guide at an appropriate future time. In the interim, I hope AICPA will strongly advocate to FASB that there should be no differences in valuation of investments based on type of organization. My letter to FASB on this subject is attached to provide more information about my views on this subject.

I will be happy to discuss these comments with you or committee members.

Sincerely



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July 27, 1995

Director of Research and Technical Activities
Financial Accounting Standards Board
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File Reference No. 147-C

Feddeman & Company is pleased to provide comments on the "Proposed Statement of Financial Accounting Standards: Accounting for Certain Investments Held by Not-for-Profit Organizations." Feddeman & Company is a firm providing auditing and other financial services exclusively to associations and other not-for-profit organizations. The firm is the largest and oldest organization specializing in services exclusively for these organizations in the Washington, DC area. An organization affiliated with the firm, Association Information Management Service, Inc., (AIMS) has participated in preparation of these comments. AIMS provides financial analysis for associations from throughout the United States. We believe the combined perspectives of our organizations should be considered as work on the statement is completed.

We favor accounting and financial reporting rules that are consistent for all types of organizations. Differences should reflect differences in transactions rather than differences in the type of organization that has the transaction. We are concerned with the proliferation of differences in rules based on organizational characteristics. For example, AICPA's "Proposed Audit and Accounting Guide: Not-for-Profit Organizations" points out that there are not-for-profit organizations that are outside the scope of SFAS No. 117 but the organizations are in the scope of the audit guide. Thus, the proposed guide has one set of rules for the 117 group and different rules for the gap group and both sets of rules are different from rules for investor-owned organizations or governmental entities.

Some associations may be in the 117 group, some in the gap group, and some are investor-owned. We favor consistency in accounting and financial reporting among not-for-profit organizations and between these organizations and other businesses. For example, there should not be artificial differences between the financial statements of associations and the statements of their member organizations (trade association members) or the employers of members (professional society members). We do not see the benefit to users of financial statements of different rules for different types of organizations. These differences seem to clearly violate the objectives of understandability and comparability established by SFAC No. 2.

In keeping with this objective of minimizing artificial differences in financial reporting rules, we have the following comments on the issues raised in the proposed statement:

Issue 1: This statement should require that investments by not-for-profit organizations be valued in the same way as investments of other organizations. Except as discussed in response to issue 2, we believe the proposed statement meets this objective.

Issue 2: Standards applicable to not-for-profit organizations should be the same as those established by SFAS No. 115 including a classification of "held-to-maturity securities" that are valued at amortized cost. It is likely that not-for-profit organizations will not have "trading securities," but if they do, they should be valued in accordance with SFAS No. 115. With respect to the basis for the difference explained in paragraph 50, we believe the fair value that is most relevant to donors and others is the value they are accustomed to from their experience with other organizations.

Issue 3: Not-for-profit organizations should report debt securities at amortized cost if they have the intent and ability to hold the securities to maturity as defined by SFAS No. 115. The arguments in paragraph 53 were rejected when SFAS No. 115 was adopted. Nothing about the nature of not-for-profit organizations makes these arguments more persuasive for this type organization. The arguments in favor of amortized cost expressed in paragraph 52 are appropriate. If a not-for-profit organization has the investment strategy described in paragraph 54, the appropriate valuation rules should apply the same as to any other organization. Paragraph 47 seems to say that board conclusions are based on the perceived frequency of a transaction occurring. One of the questions in issue 3 implies that the board's decision will be swayed by information about the volume of "hold-to-maturity securities" transactions by not-for-profit organizations. We do not believe the volume of transactions is a

valid criteria for a decision on this issue. If a not-for-profit organization follows a strategy of holding securities to maturity, the valuation rules applicable to organizations with a similar strategy are also appropriate.

Issue 4: The same latitude in the amount or detail and manner of presenting required information should be available to not-for-profit organizations as any other organization.

Issue 5: The same disclosures should be required by not-for-profit organizations as other organizations. If an organization chooses to voluntarily provide additional information, they should be permitted to do so but such action by a few should not subject others to the same disclosures unless all organizations have the same requirement.

Issue 6: Disclosures concerning gains and losses should be the same for not-for-profit organizations as other organizations. If the gains and losses are donor restricted, the normal rules for such transactions should apply. Securities transactions of a not-for-profit organization are unlikely to be part of their ongoing major or central activity. Therefore, the financial results of securities trades and value changes that are not donor restricted will be reported as gains or losses, not as revenues or expenses.

Issue 7: Endowment gains and losses are one of the few types of transactions that occur only among not-for-profit organizations. Therefore, special rules for this type transaction are needed. The proposed rules are reasonable.

In conclusion, this statement should simply apply SFAS No. 115 to not-for-profit organizations and provide guidance concerning gains, losses, and value changes on donor-restricted funds.

Sincerely yours,

W. Kent Feddeman

W. Kent Feddeman, CPA
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Feddeman & Company, P.C.

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August 14, 1995

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Dear Ms. Schumacher:

Attached is our response to the AICPA Exposure Draft of a Proposed Audit and Accounting Guide, *Health Care Organizations.*

Very truly yours,

Benjamin S. Neuhausen

Benjamin S. Neuhausen

PM

Attachment

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August 14, 1995

Ms. Annette J. Schumacher
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Dear Ms. Schumacher:

We are pleased to submit our comments on the Exposure Draft of a Proposed Audit and Accounting Guide (the Proposed Guide), *Health Care Organizations.*

Overall Context for Our Comments on the Proposed Guide

In our comment letter dated February 1, 1990, on the FASB's Invitation to Comment, *Financial Reporting By Not-For-Profit Organizations: Form and Content of Financial Statements*, we raised the issue of lack of conformity among an industry group served by not-for-profit, for-profit, and governmental organizations. Our concern about this issue is perhaps strongest in the health care industry. Not-for-profit health care entities generally are not heavily reliant on contributions and generate substantial revenues from services to patients. Further, not-for-profit health care entities compete with for-profit and governmental health care entities for customers and for debt capital. Accordingly, we believe that wherever possible the final Audit Guide should adopt provisions that minimize the differences in reporting between for-profit, not-for-profit, and governmental health care entities.

Specific Issues for Comment

Issue 1: Donations of long-lived assets or cash or other assets that must be used to acquire long-lived assets. The proposed Guide provides that (i) the contribution should be reported separately from operating results and (ii) the expiration of donor-imposed restrictions with respect to contributions of long-lived assets (or cash or other assets that must be used to acquire

long-lived assets) should be recognized when the asset is placed into service. As discussed in greater detail below, we agree with both provisions.

As noted in the introduction, most not-for-profit health care entities generate substantial revenues from services to patients. Regardless of whether a long-lived asset is donated, purchased with funds donated for that purpose, purchased with borrowed funds, or purchased with equity funds, the revenues it generates and its depreciation cost will be the same. Therefore, the reported operating results from that asset should be the same regardless of how its acquisition was funded. By excluding these donations from operating results, the proposed Guide achieves that objective.

Given that the contribution is excluded from operating results, it is most logical to require recognition of the expiration of donor-imposed restrictions at the date the asset is placed into service. Patient revenues, rather than the expiration of the restrictions, is the means of recovering the asset's cost. Revenues and costs are both reflected, and "matched," in the operating results. Therefore, it is unnecessary to spread recognition of the expiration of restrictions over the useful life of the asset. Immediate recognition when the asset is placed into service is simpler, and requiring one method enhances comparability among health care entities.

We believe the intention of paragraph 10.13 is that *both* contributions of long-lived assets and the release of long-lived assets from restrictions should be reported separately from operating results. Neither should be part of operating results, and there is no logical reason to treat them differently. However, we are concerned that paragraphs 10.8 and 10.9 are unclear and may create confusion in this regard. Paragraph 10.8 says that donations are reported as "revenues or gains" and that upon expiration of restrictions "temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of activities as 'net assets released from restriction.'" Paragraph 10.9 also refers to reporting as "net assets released from restriction." Revenues, gains, and net assets released from restriction are reported as part of operating results in the illustrative financial statements in FASB Statement No. 117. To alleviate confusion, we suggest that the fourth bullet point in paragraph 10.13 be reworded as "Contributions of long-lived assets or cash or other assets that must be used to acquire long-lived assets and the expiration of related restrictions on such assets." Also, cross references to 10.13 should be added to 10.8 and 10.9.

Issue 2: If the FASB adopts a fair value approach, should the changes in the valuation allowance related to debt and equity securities be included above the operating income caption in

the statement of operations? No. In our comments on the FASB Exposure Draft (ED), *Accounting for Certain Investments Held by Not-for-Profit Organizations*, we stated that:

> ...we are concerned about the non-comparability that would result from diverse accounting for investments by not-for-profit and for-profit entities in the same industry. Our main concern relates to the health care industry....Both for-profit and not-for-profit hospitals compete for capital, and diverse accounting for similar investments by entities in the same industry may impair users' ability to compare one entity with another.
>
> We suggest that the Board study whether users of hospital financial statements would find more useful (1) the method proposed in the ED for not-for-profit hospitals, and the Statement 115 method for other hospitals, or (2) that all hospitals measure investments following Statement 115. We would support the Statement 115 method for all hospitals if users preferred that approach.

If the FASB adopts a fair value approach, we believe comparability between the operating results of for-profit and not-for-profit health care entities will be greatest if changes in the valuation allowance for investments (other than trading accounts) are excluded from operating results. Under Statement 115, for-profit health care entities (i) report changes in their valuation allowances for available for sale securities in a separate component of shareholders' equity and (ii) carry held-to-maturity debt securities at amortized cost. Thus, changes in the valuation allowances of for-profit entities affect neither operating income nor earnings. As a result, we believe changes in the valuation allowances for investments (other than trading accounts) of not-for-profit entities also should not affect operating income.

Other Comments

Scope. Paragraph 1.2.d. and footnote 1 on page 63 state that health care providers that derive their revenue principally from voluntary contributions rather than from patient charges should follow the AICPA Audit and Accounting Guide, *Audits of Not-for-Profit Organizations*. We disagree. We believe that all health care providers should follow the proposed Guide. We believe the common attributes of the line of business are more important than the source of funding.

Classification of investments. The classification of investments as current or noncurrent should be consistent with GAAP. Paragraph 6 of Chapter 3A of ARB No. 43, *Current Assets and*

Liabilities, states that cash and claims to cash that "are designated for expenditure in the acquisition or construction of noncurrent assets, or are segregated for the liquidation of long-term debts" shall be excluded from current assets. The illustrative financial statements for Sample Not-for-Profit Hospital in the proposed Guide, however, appear to present all investments with maturities of one year or less as current, even though the dollar amount of those investments is far in excess of current liabilities. The implication of the illustrative financial statements is that short-maturity investments must be classified as current even if the hospital's board had designated some for acquisition of noncurrent assets. We suggest clarifying the illustrative financial statements to confirm that classification based on board designation continues to be applicable.

Format of Statement of Operations. The proposed Guide precludes presenting a non-operating income/expense section in the statement of operations. Only the specific items set forth in paragraph 10.13 may be excluded from operating income (or loss). This is more restrictive than the format of a for-profit entity's income statement. SEC Regulation S-X, Rule 5-03, specifically provides for non-operating income (dividends, interest income on securities, net gains on securities, and miscellaneous other income) and non-operating expense (net losses on securities and miscellaneous other deductions). In the interest of providing the greatest comparability between the reporting of for-profit and not-for-profit health care entities, we believe the final Guide should permit more flexibility in the format of the statement of operations. Guidance should be provided about items that must be included in operating income, for example, equity in the earnings of affiliated enterprises accounted for by the equity method, amortization of identifiable intangible assets used in the business and goodwill, restructuring and impairment charges, etc., similar to guidance the FASB and SEC have provided to for-profit enterprises.

Premium revenue. Paragraph 10.15 of the proposed Guide requires separate presentation of revenues from capitation arrangements. However, the proposed Guide has little guidance on revenue recognition practices for capitation arrangements. We believe more guidance is needed, particularly in terms of how to measure incurred but not reported claims (including adjustments for seasonality factors where appropriate) and how to account for participation in bonus pools. If additional guidance can be incorporated without delaying the final Guide, it should be incorporated. Otherwise, the Health Care Committee should undertake a separate project to provide more guidance.

Effective Date. We understand the desire to have the final Guide become effective at the same time as FASB Statements Nos. 116 and 117, to avoid back-to-back accounting changes. Because the final Guide will not be issued until 1996, however, we believe the proposed effective date of periods beginning after June 15, 1995, is too soon. Entities with June 30 fiscal years will have

little lead time to assimilate and implement the new Guide. Therefore, we suggest delaying the effective date to periods beginning after December 15, 1995, with earlier application permitted.

We urge the Task Force, the Health Care Committee, and AcSEC to issue the final Guide as early in 1996 as possible, to permit the largest number of June 30 fiscal year-end entities to adopt the provisions of the Guide and Statements 116 and 117 simultaneously.

Business Combinations and Less-than-Controlling Interests

Our sense is that mergers, acquisitions, joint ventures, and less-than-controlling interests in not-for-profit entities are proliferating in the health care industry. More guidance is needed to account for these transactions. The existing guidance for mergers and acquisitions in APB Opinion No. 16 is oriented toward for-profit enterprises and is difficult to apply to transactions among not-for-profit entities. The guidance in paragraph 11.28 of the proposed Guide, while helpful, is inadequate. Similarly, the guidance in APB Opinion No. 18 regarding use of the equity method contemplates for-profit enterprises and is difficult to apply to investments in not-for-profit entities. Some investors apply the equity method on the grounds that the investments are analogous to joint ventures or partnerships; other investors apply the cost method on the grounds that the investor in a not-for-profit entity does not have the ability or the expectation of receiving dividends or proceeds from liquidation of the investee entity. Often the decision varies based on the state law governing the investee entity.

We believe that preparers and practitioners need more guidance on the accounting for these transactions. It would not be appropriate, however, to add guidance on these areas in the final Guide without exposure for public comment. We suggest that the Health Care Committee establish a separate project to provide guidance in these areas. We would be pleased to work with the Committee or a designated Task Force on such a project.

We appreciate this opportunity to comment on the proposed Guide. We would be pleased to discuss our views with members of the Task Force, the Committee, AcSEC, or the AICPA staff, at their convenience.

Respectfully submitted,

Arthur Andersen LLP

MultiCare

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August 15, 1995

Annette J. Schumacher
Technical Manager
General Government Division, AICPA
1455 Pensnsylvania Avenue NW
Washington, DC 20004-1081

File Reference No. H-1-500

Dear Ms. Schumacher:

This letter is in response to your request for comment on the exposure draft titled "Proposed Audit and Accounting Guide, Health Care Organizations" and specifically addresses the accounting treatment identified as Issue 2.

Issue 2:

It is our opinion that if the FASB adopts a fair value approach for debt and equity securities, the change in valuation allowance should not be included in operating income. We believe not-for-profit organizations should be allowed to follow the accounting and reporting requirements established in Statement 115, specifically, that not-for-profit organizations should be allowed to report changes in value of available-for-sale securities as a separate component of net assets.

The ability to compare our financial data with data collected from other health care providers is vital to our efforts to cut costs and become as efficient as possible. If we are forced to use accounting methods which are different from for-profit health care providers, comparability is lost.

Sincerely,

Anita Edwards
Manager, Cash Management and Investments

Governmental Training Solutions

August 16, 1995

Annette J. Schumacher
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AICPA Federal Government Division
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Delivered via facsimile
202-638-4512

RE: File H-1-500, Proposed Audit and Accounting Guide, "Health Care Organizations"

I apologize for the delay in submitting my response on the Proposed Audit and Accounting Guide,"Health Care Organizations" and I hope you can still include this response in your analysis.

Overall, the Proposed Audit guide is very well written. The guidance to implement the provisions of FASB Statements 116 and 117 are concise and well-organized. I am particularly impressed with the numerous references to GASB guidance for governmental entities where there are differences from FASB guidance. In the GASB discussions of the guidance for not-for-profit organizations, FASB, GASB and the AICPA seem to be waiting on the "other guy" to define governmental entities. In my opinion, the description in ¶1.2(c) on page 2 provides excellent guidance for distinguishing governmental entities. I have recommended in my comments on the not-for-profit audit guide that this provision be included there as well.

My comments on specific issues are summarized in the following paragraphs:

ISSUE 1: EXPIRATION OF DONOR-IMPOSED RESTRICTIONS ON LONG-LIVED ASSETS

While I understand the desire to achieve consistency in financial reporting, I think the issue is mute once FASB provides an optional accounting treatment. If certain not-for-profits organizations are allowed to follow either recognition while others are restricted to only one, consistency among not-for-profits is lost anyway. One reason that readers of financial statements are so confused is that the rules are so complex and change from one entity to another. If FASB (or GASB) allows flexibility in reporting, restrictions in the AICPA audit guides won't resolve the confusion for readers.

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ISSUE 2: ACCOUNTING FOR INVESTMENTS

The changes in the valuation allowance related to debt and equity securities should not be reported above the operating income caption unless investments are a significant component of the operations of the health care organization. The organizations described in the Preface as being within the scope of the Guide do not appear to be in the investment business. The exception may be the continuing care retirement communities, if the organization holds investments that were transferred to defray client/member costs. Investment activities that are incidental to the operations of most other organizations are reported below the operating caption.

OTHER ISSUES:

1) Page 9, ¶2.16, discusses the application of SAS 55 to the audits of health care organizations. The ASB has already issued proposed revisions to SAS 55 based on the recommendations of the COSO report. This section should reference the provisions of COSO, at a minimum, or the proposed (or final if available) revisions to SAS 55. Since the components of the internal control structure have changed, the revisions will be significant and auditors should be alerted to this issue.

2) Page 11, ¶2.22, outlines the provisions of SOP 94-6 related to accounting estimates. The ED for this SOP included governments, but the final document did not. It was my understanding that SOP 94-6 does not apply to governmental entities. If that is true, the difference should be mentioned in this paragraph.

3) Page 19, ¶2.53, directs auditors to the guidance for requirements of the Single Audit Act. OMB has published proposed revisions to Circular A-133 in the Federal Register and GAO has presented proposed revisions for the Single Audit Act to the House Committee for consideration. These potential changes are significant and auditors should be alerted to watch for final publications.

4) Page 79, ¶12.7 discusses special reports that may be required in conjunction with audit reports of health care organizations. The reporting requirements for Single Audit reports are significant and complex. SOP 92-9 and the ASLGU should be mentioned here to alert auditors about these reporting requirements. In addition, I would suggest that the Guide include a list of the types of reports required and a brief description of the contents, with references to the examples in SOP 92-9 or the ASLGU.

I appreciate the opportunity to respond on this ED. If you have any questions, or need additional information, please do not hesitate to contact me at our Berea office.

Sincerely,

Betty Pendergrass King, CPA
President

GTS\HCO9508

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[illegible]
[illegible]
[illegible]

August 11, 1995

Annette J. Schumacher
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Re: Exposure Draft - Proposed Audit and Accounting Guide - Health Care Organizations

Dear Ms. Schumacher:

Allina Health System appreciates this opportunity to comment on the Proposed Audit and Accounting Guide for Health Care Organizations.

Allina Health System is a not-for-profit, integrated healthcare system based in Minneapolis, Minnesota. It was formed by the combination of HealthSpan Health Systems Corporation and Medica in August 1994. Net revenues are approximately two billion dollars. Allina is composed of the following three operating groups:

- ***Delivery Service Group (DSG)*** - includes hospitals (twelve owned and five managed), nursing homes (two), medical transportation, home health care, medical equipment and other diversified businesses.

- ***Professional Services Group (PSG)*** - includes a group practice organization of 400 physicians in clinics in more than 40 locations in Minnesota and Wisconsin.

- ***Health Plans Group (HPG)*** - offering Medica (a health maintenance organization) managed care products and Select Care preferred provider networks and managed care products for 880,000 covered lives.

We believe that consistency and comparability of financial reporting in the healthcare industry is important to meet the needs of the users of those financial statements. However, under the proposed guide, the healthcare industry's accounting and financial reporting has divergent valuation methods, accounting principles and financial statement presentations by type: for profit, not-for-profit and governmental. The not-for-profit organizations finance their capital needs principally from the proceeds of debt issues and their operating needs principally from service charges rather than from private philanthropy or government grants or subsidies. Consequently, under the current AICPA Audit and Accounting Guide, Audits of Providers of Health Care Services, the not-for-profit healthcare organizations had financial reporting similar to the for-profit healthcare organizations. Under the proposed guide, however, financial reporting of the not-for-profit healthcare organizations will differ from the for-profit healthcare organizations. In addition, the proposed guide indicates it will be revised upon issuance of a FASB Statement "Accounting for Certain Investments Held by Not-for-Profit Organizations" which differs from FASB No. 115 which is effective for the for-profit healthcare industry.

Significant differences and issues can be summarized as follows:

	Not-For-Profit	For-Profit
Balance Sheet		
Investments	✦ Exposure Draft, Accounting for Certain Investments Held by Not-For-Profit Organizations	✦ FASB No. 115 - uses a three category approach
Net Assets (equity)	✦ 3 Classes	✦ Equity
Statement of Operations		
Revenue	✦ Includes net assets released from restrictions ✦ Includes interest income (including interest of restricted assets)	✦ Includes investment gains/losses under FASB No. 115

Specific Issues for Comment

Issue 1: Operating Measure

The Draft recommends the use of an operating measure which would include all items of revenues, expenses, gains, and losses except those specified in paragraph 10.13. The main change from current practice is the inclusion in the operating measure of all items that are currently classified as "non-operating". Currently, non-operating gains/losses include investment income and gains/losses, contributions, and a number of other transactions that fall within the

non-operating definition of the current Audit and Accounting Guide, "Audits of Providers of Health Care Services" (the Guide).

In current practice, the major items reported as "non-operating" include unrestricted investment income and gains/losses, unrestricted contributions, tax support and subsidies, equity in income of affiliates accounted for by the equity method, and a number of miscellaneous items. We believe that the distinction of revenue, expenses, gains, and losses between "operating" and "non-operating", as is done currently in practice, will result in more meaningful comparisons, not only among not-for-profit health care organizations, but also comparisons of not-for-profit organizations to for-profit health care organizations. We strongly believe that the flexibility in presentation given to for-profit healthcare organizations should be given to not-for-profit healthcare organizations to distinguish between operating activities and other income and expense items unrelated to operations.

The operating results, as reported in current practice, are viewed as an important measure of financial performance of health care providers by many users of financial statements, including the trustees and holders of tax-exempt debt (virtually all significant not-for-profit health care organizations have tax-exempt debt outstanding), the investment community, rating agencies, and organizations that provide benchmarking information. In addition, governing boards and managers of health care organizations view operating results as a critical indicator of financial performance. The inclusion in an operating measure of items such as investment income and gains/losses would hinder comparison of health care organizations because the amount of investments and related income and gains/losses varies widely among health care entities. This disparity will become greater upon FASB's issuance of the proposed standard for "Accounting for Certain Investments Held by Not-for-Profit Organizations," if changes in market value were to be included within the operating measure. Accordingly, we recommend that the current classification of "operating" and "non-operating" items be retained or flexibility in presentation be given to the not-for-profit healthcare organizations as currently given to the for-profit healthcare organizations.

Issue 2: Expirations of Donor-Imposed Restrictions on Long-Lived Assets

FASB Statement No. 116 permits preparers to recognize the expiration of donor-imposed restrictions on long-lived assets either (1) when the asset is placed into service or (2) over the useful life of the asset (see paragraph 10.9). The proposed Guide eliminates the latter option by requiring that the expiration of the restriction be recognized when the asset is placed in service. The purpose of this limitation is to achieve consistency of reporting for not-for-profit health care organizations, especially with respect to the operating measure.

Although the Guide is more restrictive than Statement No. 116, the restriction relates to the definition of an operating measure. FASB Statement No. 117 permits AICPA Audit and Accounting Guides to provide more specific reporting guidance for certain not-for-profit organizations, and reporting an operating measure was specifically considered in the deliberations relating to that permission.

Is this restriction appropriate for health care organizations?

We believe that the recognition of the expiration of donor-imposed restrictions on long-lived assets should be presented outside the operating (and non-operating) sections, in the same manner as contributions of long-lived assets as recommended in paragraph 10.13. We do not believe there is a substantial difference between the receipt of long-lived assets as a contribution, or the receipt of cash or other assets that have been restricted by the donor for the acquisition of long-lived assets. Therefore, we believe that the expiration of donor-imposed restrictions on long-lived assets should not be recognized within the operating (or non-operating section) of the Statement of Operations as "net assets released from restrictions". If this recommendation is adopted, then we agree with the Draft's restriction relating to the reporting of expirations of donor-imposed restrictions on long-lived assets. If our recommendation is not adopted and the expiration of donor-imposed restrictions on long-lived assets is reported within the operating measure (or within a non-operating measure), we believe that the restriction in the Draft is not appropriate for health care organizations.

At times, health care organizations receive significant donations that are restricted for the acquisition of long-lived assets, either through a capital campaign or significant individual gifts or bequests. Recognizing revenue (net assets released from restrictions) when these funds are spent and the capital additions are placed in service can result in significant distortions in the operating measure. Accordingly, if the format of the operating measure in the Draft is retained, we believe that both alternatives under FAS No. 116 should be allowed (at least for significant non-recurring transactions) to minimize distortion in the operating measure.

Issue 3: Accounting for Investments

The FASB is currently developing guidance on accounting for certain investments held by not-for-profit organizations. This project may result in a required fair value approach for certain securities held by not-for-profit organizations. Prior to the adoption of FASB Statement No. 117, changes in the valuation allowance of investments were often reported as a component of the statement of changes in fund balance. FASB Statement No. 117, in effect, replaced the statement of fund balance with the required statement of activities. However, in addition to the statement of activities, this Guide would require not-for-profit health care organizations to present a statement of operations that would include most changes in the valuation allowance. At present, the Guide would require most changes in valuation allowance for marketable equity securities portfolios to be included above the operating income caption in the statement of operations (see paragraph 4.13).

If the FASB adopts a fair value approach, should the changes in the valuation allowance related to debt and equity securities (referred to above) be included above the operating income caption in the statement of operations?

No, we believe changes in the valuation allowance related to debt and equity securities should

be included in a "non-operating" section of the income statement so that investors and other financial statement users can distinguish between efficiency of operations and fluctuation of investment reserves.

We believe that FAS No. 115 should be applicable to not-for-profit health care organizations that fall within the applicability of the Draft. Below we offer our suggestion for reporting changes in market value of investments regardless of the approach that is finally adopted for reporting changes in market value.

If the proposed FASB guidance on "Accounting for Certain Investments Held by Not-for-Profit Organizations" is issued in final form, we believe that the changes in the valuation allowance (i.e., changes in market value or unrealized holding gains and losses) related to marketable debt and equity securities should not be included in the operating measure in the Statement of Operations. The reporting of valuation allowances (changes in market value) should be reported as follows:

(a). If FAS 115 is applicable, valuation allowances relating to trading securities should be reported as a "non-operating" item in the Statement of Operations (see comment No. 1 for our recommendation as to the operating measure) and valuation allowances relating to available-for-sale securities should be reported similar to the items described in paragraph 10.13.

(b). If FAS 115 is not applicable, all valuation allowances should be reported similar to the items described in paragraph 10.13.

Issue 4: Investments-Current Guidance

Chapter 4 of the Draft deals with the accounting and reporting for marketable securities. We assume that this chapter will be replaced upon the issuance by FASB of its proposed standard on "Accounting for Certain Investments by Not-for-Profit Organizations". Should this not be the case, we believe that Chapter 4 should be clarified to discuss the reporting of valuation allowances for debt securities, when such debt securities are reported at the lower of cost or market value. Currently, the Draft discusses the reporting of the valuation allowance for marketable equity securities (paragraph 4.13), but does not discuss the accounting for valuation allowances for debt securities. Additionally, paragraph 4.13 should be modified so as not to require valuation allowances to be reported within the operating measure (see our comment No. 1 with respect to the operating measure).

Issue 5: Applicability

Paragraph 1.2 of the Draft indicated that not-for-profit, nonbusiness-oriented, health care organizations are voluntary health and welfare organizations as defined in FAS No. 117 and fall within the scope of the AICPA Audit and Accounting Guide "Audits of Not-for-Profit Organizations", rather than the Draft. The distinction between not-for-profit, nonbusiness-

oriented organizations and not-for-profit, business-oriented organizations (to which the Draft applies) is driven by the amount of fees the organization receives for goods and services as compared to the amount of contributions it receives. The description of not-for-profit, business-oriented organizations indicates that they may receive "contributions of relatively small amounts". Without further clarification, it is unclear as to what level of contributions would categorize an organization into a business-oriented or a nonbusiness-oriented organization. For example, some health care entities receive contributions that are significant amounts, but may only represent a fairly small portion (e.g., less than 10%) of the total revenues of this organization. Also, an organization may receive a significant contribution in one year but may not receive a significant amount of contributions on a recurring basis. We suggest that the description in paragraph 1.2 be revised to clarify applicability of the Draft.

w/ Terry's response

Issue 6: Business Combination

Paragraph 11.28 of the Draft addresses the accounting for business combinations. The Draft states that "A change in control, such as a change in sole corporate member, should be accounted for similar to a pooling of interests". The term "similar to a pooling of interests" is confusing - is the pooling of interests accounting to be applied, or some other accounting method that is similar to a pooling of interests? Practice in the not-for-profit industry has varied because changes in control often do not meet the criteria specified in APB Opinion No. 16 for a pooling of interests transaction.

In some cases, a change in sole corporate membership has been accounted for by reporting an increase in fund balance by the acquiring organization of the net assets (at carrying value) of the organization being acquired as of the transaction date. Subsequently, financial statements of both organizations are reported on a combined basis. However, financial statements of the acquiring organization prior to the transaction date. Subsequently, financial statements of both organizations are reported on a combined basis. However, financial statements of the acquiring organization prior to the transaction have not been restated for the combination, as they would be in a true pooling of interests transaction. In effect, this is a pooling of interest accounting without the restatement of prior periods' financial statements for the pooling. If this type of accounting is considered to continue to be acceptable, clarifying language should be added to the Draft. Conversely, if the pooling of interests accounting under APB Opinion No 16 is to be strictly followed, this should be clarified.

Bill F. response (comp w. AA comment)

Issue 7: Current/Non-current Classification of Investments

The illustrative financial statements for Sample Not-for-Profit Hospital show investments classified as current and non-current assets. The footnotes indicate that investments in debt securities with original maturities of more than one year and that are not intended to be used fro current operations, donor-restricted endowment gifts, and assets limited as to use and not needed to meet current liabilities are classified as non-current assets. All other investments are classified as current assets. The illustrative financial statements seem to imply that investments not restricted by donors or contract be included in current assets. Many health care

organizations have substantial investment funds that are not intended to be used for working capital purposes, and are currently classified as non-current assets. We suggest that the Draft provide specific guidance on the classification of investments in the chapter on investments.

Issue 8: Premium and Capitation Revenues

In paragraphs 1.10 and 1.19 the Draft discusses the reporting of premium and capitation revenues. Generally premium and capitation revenues are paid to the provider monthly and obligate the provider to render covered services during the month. The Draft states that those revenues are generated as a result of an agreement to provide health care services, rather than from the actual provision of health care services.

Typically, capitation contracts cover an annual period and require monthly premiums to the health care entity. In entering into such a contract, the health care provider typically has an expectation of a certain level of services that will be rendered under the contract. If those service levels occur ratably over the period of the contract, the practice of recording monthly capitation payments as revenues will result in an appropriate matching of revenues and expenses. However, where the services under the contract may fluctuate based on seasonality or other factors, recording revenue on a monthly basis (i.e., in equal monthly amounts) may not result in a matching of revenues and expenses. We suggest that paragraph 1.19 be expanded to indicate that seasonality or other expected fluctuations of health care services be considered in the recognition of revenues from a capitation contract.

In paragraphs 10.3 and 10.15, the Draft recommends that premium and capitation revenue be disclosed separately in the financial statements. We agree that premium revenue earned by a health maintenance organization should be reported separately. However, we believe that payments to a health care provider under a capitation contract are merely a payment method for health care services, similar to being paid specific amounts per diem, per discharge, etc. We, therefore, believe that capitation arrangements by health care providers are payments for health care services and should be included in patient service revenue.

Issue 9: Illustrative Financial Statements

The illustrative financial statements of Sample Not-for-Profit Hospital should be expanded to present illustrations of certain transactions that are not presently shown, such as the following:

- Investments gains/losses, and valuation allowances
- Investments transactions and disclosures in conformity with the proposed FASB standard on "Accounting for Certain Investments Held by Not-for-Profit Organizations" (if issued before the final guide is issued)
- FAS No. 115 reporting of investments for a for-profit subsidiary included in the consolidated financial statement of a not-for-profit health care organization
- SOP 94-6, "Disclosure of Certain Significant Risks and Uncertainties"
- Unrestricted gains on investments of permanently restricted net assets (the present

disclosure under the heading "temporarily and permanently restricted net assets" in Note 1 is not clear)

- Capitation revenue with related footnote disclosure
- Agency funds (contributed resources held by an unconsolidated foundation that constitutes agency transactions)

Issue 10: Differences between the Draft and FAS 117

The Draft is more restrictive than FAS No. 117 in several areas, including the following:

- The use of a current/non-current classification for the balance sheet
- The classification of revenues, expenses, gains and losses and reporting of an operating measure
- The presentation of financial statements
- The reporting of donations for long-lived assets

In the hierarchy of generally accepted accounting principles, FASB standards provide the highest level of guidance. If the AICPA and FASB concur that the Draft should govern reporting in the areas mentioned above (in effect, the Draft is the highest level of GAAP), we suggest that a statement to that effect be made. Without such a statement, we believe that there will be confusion in practice in implementation of the Draft.

Issue 11: Effective Date

The effective date of the Draft is for financial statements for periods beginning after June 15, 1995. In view of the delay in issuing the final Draft, we suggest that the effective date be moved to an appropriate later date.

Issue 12: Inconsistencies Among Exposure Drafts

We believe that not-for-profit business-oriented health care organizations (see definition in paragraph 1.2.b. of the Draft) are not not-for-profit organizations as defined in FAS 117, since by definition they do not receive significant amounts of contributions. Although these entities are covered by the Draft, we believe they should follow FAS 115 for accounting and reporting investments. If FAS 115 is not deemed appropriate, we believe that not-for-profit health care organizations should at least have the ability to carry debt securities, for which it has ability and intent to hold to maturity, at amortized cost.

The Draft does not contain any reference to any health care entity that is not organized for for-profit purposes being able to adopt the provisions of FAS No. 115, or being exempt from the functional reporting requirements. The Exposure Draft of the Proposed Audit and Accounting Guide for Not-for-Profit Organizations (the NFP Draft) states in paragraph 1.04 that not-for-profit organizations (those that are not organized for for-profit purposes) that do not meet the FASB Statement No. 17 definition of a "not-for-profit organization" are required to follow generally

accepted accounting principles (GAAP) for for-profit entities. Although those types of entities are required to follow the not-for-profit guide (the NFP Draft), they are required to follow GAAP for for-profit entities with respect to those pronouncements that conflict with the NFP Draft. The only pronouncement that is referred to in the NFP Draft as contradictory is FAS 115 (see footnote 2 on page 2 of the NFP Draft). The NFP Draft also exempts certain not-for-profit organizations not meeting the definition of "not-for-profit organizations" from the requirement for functional reporting (see paragraph 3.15)

The key elements of the definition of "not-for-profit organizations" relate to (a) receipt of significant amounts of contributions, (b) operating purposes other than to provide goods or services at a profit, and (c) absence of ownership interests like those of business enterprises. It seems not-for-profit organizations by definition are not organized to make a profit (they may have to make a profit to stay viable, but that is not their organizational purpose) and do not have ownership interests like an investor-owned organization. Accordingly, those organizations not meeting that definition would not meet it because they do not receive significant amounts of contributions. For those organizations, then, the NFP Draft applies except for accounting and reporting for investments (for which those organizations need to adopt FAS 115) and for reporting of expenses (functional reporting is not required).

There is no similar provision in the Draft of the Health Care Audit and Accounting Guide. Although some health care organizations receive significant amounts of contributions, most do not; nonprofit HMO's generally receive no contributions. If this provision in the NFP Draft were to be included in the Health Care Draft, most not-for-profit health care organizations would be required to follow FAS No. 115 and be exempt from functional reporting. We do not understand why this provision is contained in the exposure draft of the not-for-profit guide but not in the health care guide. We believe it should be included in both or neither guides. Moreover, if included in these not-for-profit and health care guides, we believe a similar provision should be incorporated in the FASB standard on "Accounting for Certain Investments Held by Not-for-Profit Organizations", along with reporting guidance for reporting of FAS 115 holding gains and losses within the context of the FAS No. 117 prescribed financial statements.

If the provision relating to FAS No. 115 is retained, we suggest that the final draft be revised to incorporate guidance on the classification of investments when investments are managed by outside professional organizations. For instance, many not-for-profit organizations with substantial amounts of investment funds engage professional investment mangers to manage the investments. These managers typically have complete authority (within certain policy guidelines established by the not-for-profit organizations) to buy and sell investment securities within the pool managed by investment managers. Therefore, would the entire investment pool be classified as trading or as available-for-sale securities?

We believe that the provision in paragraph 1.04 and 3.15, relating to the application of FAS 115 and the exemption from function reporting, will lead to many reporting problems and inconsistencies because of the interpretation that is required to determine whether or not an entity falls within the "not-for-profit organization" definition (e.g., what are "significant amounts" of

contributions?). These different interpretations will impair comparability of similar types of organization. This lack of comparability will be magnified if additional FASB standards are issued that apply to for-profit organizations. Therefore, we question whether these provisions will result in improved reporting for the health care or other not-for-profit industry.

Issue 13: Reference to Not-for-Profit Organizations Audit and Accounting Guide

There are a number of accounting and reporting issues that health care organization may have as a result of FAS 116 that are not addressed in the Draft, but that are described in the Exposure Draft of the Proposed Audit and Accounting Guide of Not-fro-Profit Organizations (e.g., extensive discussions of contributions, including distinctions between contributions, exchange transactions, and agency transactions, and guidance concerning endowment funds, split-interest agreements, and contributed services.) In order to assure that preparers of financial statements refer to the appropriate guidance, we suggest that the Draft include some language to refer the reader to the NFP Draft with respect to those transactions.

Thank you for the opportunity to comment. If you would like to discuss our comments, you may reach us at (612) 992-3666 or (612) 992-3334.

Respectfully submitted,

Richard Blair
System Vice President Finance and Administration,
Chief Financial Officer, and Treasurer

Laurie Lafontaine
Vice President, Audit Services

DB:lso

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Attention: Ms. Annette J. Schumacher, Technical Manager
Federal Government Division

Re: File H-1-500

Gentlemen:

I reviewed the exposure draft of the proposed Audit and Accounting Guide, "Health Care Organizations". Although the draft does a good job with the accounting guidance, it could be greatly improved in the auditing area. Here are my specific comments:

Pages 15- 16: More guidance is needed on auditing for compliance with Medicare and Medicaid requirements, since these have a direct effect on the financial statements. How does the auditor obtain satisfaction that the services were performed and will be paid by Medicare? In most cases, auditors will need to use a medical specialist (either a doctor, nurse or technician) to audit a health care provider.

Section 2.16 on internal control structure should be rewritten for the revised definition of internal control (see exposure draft February 23, 1995). Guidance on how to evaluate risk assessment and monitoring functions in health care organizations should be included.

Materiality -- the guide needs guidance on materiality, especially for not for profit and governmental health care entities. For not-for profit entities, the auditor should consider the need for separate materiality amounts for unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets. After the auditor determines planning stage materiality, he needs to consider (allocate) the materiality for various cycles (accounts) and assertions. Illustrations of this would be helpful. In evaluating whether misstatements are material, the auditor needs to consider the individual effect of projected misstatements (and sampling risk) on unrestricted net assets, temporarily restricted net assets and permanently restricted net assets.

Investments -- include guidance in Exhibit 4.1 on evaluating whether the entity can hold investments to maturity

Confirmation of receivables -- the Guide should indicate a presumption that these receivables should be confirmed; confirmation is usually the best evidence that these receivables exist. However, the auditor may need to confirm something other than the balance, since the patient doesn't know the balance and the third party payor cannot confirm a total balance due. But patients can confirm when they were treated and what they were treated for. Third party payors can confirm specific transactions. The Guide also should warn auditors against using negative requests for these receivables, since the requirements for using negatives are rarely met in health care organizations.

The material on receivables and on revenue should be combined since these areas are closely related; guidance should be added on auditing related party transactions in this industry, since these transactions are frequent.

Malpractice insurance -- add guidance on whether it is necessary to confirm coverage with the carrier and to evaluate the financial viability of the carrier.

The guidance on page 54 concerning risk of adverse deviation is not clear as to the reason for the guidance.

The various charts under audit considerations should be enhanced. The examples of audit procedures should be divided into two columns: "examples of tests of controls" and "examples of substantive tests"; more examples of tests of controls should be included. The examples of selected control procedures should be control procedures. Those that begin "procedures ensure" are not control procedures; rather they are objectives of procedures. Audit procedures that begin "determine that" should be changed to "determine whether"; it would help if the Guide explained how to determine whether. Financial statement assertions should not be combined -- use one procedure for one assertion, so the reader can understand what procedures test what assertions.

By improving the Guide for the above matters, you will have a document that is more useful to practitioners.

Sincerely,

Abraham Akresh

Abraham D. Akresh
CPA

EXPOSURE DRAFT

PROPOSED AUDIT AND ACCOUNTING GUIDE

HEALTH CARE ORGANIZATIONS

NO. 800086

AUGUST 14, 1995

Submitted by: Louisiana Society of CPAs
Audit and Accounting Technical Standards Committee
Raymond Prince
Albert Roevens, Jr.
Mary Sanders
Judson McCann, Jr.
Keith Besson
Jon H. Flair, Chairman

Prepared by: Jon H. Flair

Issue 1 - Of the six committee members responding, three members favored the more restrictive option of recognizing the expiration of donor-imposed restrictions on long-lived assets when the asset is placed in service.

Issue 2 - All three committee members felt that the accounting for investments should be similar to the requirements under FASB 115, recording amounts in the statement of activity analogous to those required in the income statement, and recording amounts in the statement of net assets similar to those required in the statement of changes in equity.

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nysscpa

August 17, 1995

Ms. Annette J. Schumacher, Technical Manager
File H-1-500
Federal Government Division
AICPA
1455 Pennsylvania Avenue, NW
Washington DC 20004-1081

Re: Proposed Audit and Accounting Guide-Health Care Organizations

Dear Ms. Schumacher:

We are enclosing the comments of the New York State Society of Certified Public Accountants in response to the above proposed audit guide. The comments were prepared by the Society's Health Care Institutions Committee.

If you have any questions regarding the comments, please call us and we will arrange for someone on the committee to contact you.

Thank you for your consideration.

Very truly yours,

Donnell P. O'Callaghan Jr., CPA
Chairman, Health Care Institutions Committee

Walter M. Primoff, CPA
Director, Professional Programs

Enclosures

cc: Accounting & Auditing Committee Chairmen

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Comments of Health Care Institutions Committee of the New York State Society of Certified Public Accountants on Proposed Auditing and Accounting Guide - Health Care Organizations

Operating vs. Non-operating Activities

The draft audit guide has essentially eliminated any distinction between operating and non-operating activities, as currently exists today, in the Statement of Operations.

While it is recognized that certain reporting inconsistencies exist depending on how health care providers define activities that are related to ongoing, major or central operations, it is generally believed that a distinction between operating and non-operating is a more useful presentation given the many different types of health care providers Activities often classified as non-operating, such as investment income and unrestricted contributions, often vary widely among health care providers. Eliminating the non-operating distinction could make comparisons of operating results between health care providers difficult.

Some of the reporting inconsistencies that may exist today could be eliminated by better defining what activities should be classified as operating versus non-operating. One approach would be to specifically limit what is classified as non-operating activities (for example, unrestricted contributions and investment income).

In summary, it is believed that retaining some form of distinction between operating and non-operating activities would be more useful and yet still conform with the provisions of SFAS 117.

Issue 1: Expirations of Donor-Imposed Restrictions on Long-Lived Assets

The Exposure Draft requests comments on two specific items. With respect to the expiration of donor-imposed restrictions on long-lived assets there appears to be some confusion as to how contributions of long-lived assets, are to be reported in the Statement of Operations. Paragraph 10.8 and 10.9 indicate that donation of long-lived assets, cash or other assets used to acquire long-lived assets ultimately flow through the Statement of Operations either as "unrestricted support" or as "net assets released from restriction." However, paragraph 10.13 requires that certain activities be reported separately from operating results with one such activity being contributions of long-lived assets. It would appear that clarification is warranted.

Notwithstanding this apparent inconsistency, contributions of long-lived assets can often be material to the financial statements, especially in connection with major building programs. To the extent that donor imposed restrictions on long-lived assets are material and to the extent that they are included in the Statement of Operations as net assets released from restriction, then allowing both alternatives under SFAS 116 for recognizing this revenue would provide more flexibility in minimizing potential distortions from year to year.

Issue 2: Accounting For Investments

The Exposure Draft also requests comment as to whether changes in the valuation allowance related to debt and equity securities should be included as a component of operating income in the Statement of Operations. Investment portfolios in not-for-profit health care organizations vary widely depending on the characteristics of the organization (i.e., multi-hospital system vs. community hospital vs. HMO, etc.). Reporting changes in valuation allowances as a component of operating income could lead to distortions in the presentation of operating results from year to year that are unrelated to basic operations (i.e., unrelated to the provision of health care services) and potential inconsistencies when comparing operating results among health care organizations.

SFAS 115 only requires that changes in valuation allowances associated with "trading securities"be reported as a component of operating results. Under SFAS 115 changes in valuation associated with "available for sale" or "held to maturity" securities are reported as a component of stockholders' equity. A similar approach would appear warranted for health care organizations. The investment portfolios in many not-for-profit health care organizations have characteristics more similar to available for sale or held to maturity securities than trading securities. Accordingly, a more accurate and useful presentation of changes in valuation allowances associated with these securities would be to report such changes separately from operating results similar to the presentation of changes described in paragraph 10.13 of the Exposure Draft. If a not-for-profit health care organization is maintaining a trading portfolio of securities then it would be appropriate to report changes in a valuation allowance associated with these securities as a component of operating results.

JOHN R. DAY
Vice President-Controller

August 14, 1995

Annette J. Schumacher
Technical Manager
File H-1-500
Federal Government Division
AICPA
1455 Pennsylvania Ave., N.W.
Washington, DC 20004-1081

Dear Ms. Schumacher:

I have the following comments on the Exposure Draft to the Proposed Audit and Accounting Guide for Healthcare Organizations dated April 14, 1995:

1. Operating Income (Paragraph 10.14). This paragraph requires that operating income (or loss) be clearly labeled in the Statement of Operations. The sample financial statements on page 104 also show operating income labeled in the Statement of Operations. I recommend that this not be a requirement for investor owned for-profit healthcare organizations. The reason for this is that many investors and analysts use a different definition of operating income.

2. Illustrative Statement of Operations (page 104). For this illustration, I suggest a separate revenue line for "premium revenue" related to capitation revenue.

3. Definition of Premium (page 181). Premium is defined as "the consideration paid for providing contract coverage". This definition is not clear and should be expanded. For example, Charter Medical has contracts that are based on a per diem for services provided. This revenue should be classified as patient service revenue because it is not at-risk capitated revenue.

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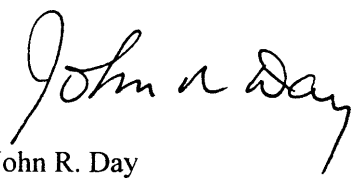
4. Accounting for Loss Contracts (pages 86 and 87). This section requires "the estimated future healthcare costs and maintenance costs to be considered in determining whether a loss has been incurred should include fixed and variable, direct and allocable indirect cost". I disagree with this concept of determining losses based on full cost allocation. I believe it is proper to compare incremental revenue from the contract with incremental cost to be incurred under the contract. If full cost is utilized in evaluating the loss from a capitated contract, this analysis would be impacted by patient mix. If utilization from other payor sources decreased, the fully allocated cost would increase.

Thank you for the opportunity to comment on this proposed Audit Guide.

Very truly yours,



John R. Day

JRD:slo

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September 8, 1995

Ms. Annette J. Schumacher
Technical Manager
Federal Government Division
American Institute of Certified Public Accountants
1455 Pennsylvania Avenue, NW
Washington DC 20004-1081

File Reference H-1-500, Federal Government Division
Proposed Audit and Accounting Guide - Health Care Organizations

Dear Ms. Schumacher:

We are pleased to comment on the AICPA's Exposure Draft of the *Proposed Audit and Accounting Guide - Health Care Organizations* (the "Exposure Draft").

We support the issuance of the Exposure Draft as a final Audit and Accounting Guide (the "Guide"). However, we recommend certain clarifications and changes as discussed below and in the Appendix to this letter.

Operating Income

Under the current Audit and Accounting Guide, *Audits of Providers of Health Care Services*, activities associated with the provision of health care services are considered to be the ongoing, major or central operations of providers of health care services. Revenues, expenses, gains, and losses related to these operations are classified as "operating." Gains and losses not related to the provider's ongoing, major or central operations, but constituting peripheral or incidental transactions or resulting from other events stemming from the environment that may be largely beyond the control of the provider and its management, are classified as "nonoperating." Under the Exposure Draft, all revenues, expenses, gains and losses with the exception of the items identified in paragraph 10.13 would be included in operating income (or loss). We believe the distinction between operating and nonoperating income as currently used in practice should be retained because it results in more meaningful comparisons, not only among not-for-profit health care organizations, but also among not-for-profit and for-profit health care organizations.

We believe operating results, as reported in current practice, are viewed as an important measure of financial performance of health care providers by many users of financial statements, including trustees and holders of tax-exempt debt (virtually all significant not-for-profit health care organizations have tax-exempt debt outstanding), the investment community, rating agencies, and organizations that provide benchmarking information. In addition, we have observed that governing boards and managers of health care organizations often view operating results as a critical indicator of financial performance.

The inclusion of items such as investment income and gains/losses in an operating measure would hinder comparison of health care organizations because the amount of investments and related income and gains/losses varies widely among health care entities. This disparity would become even greater upon the FASB's issuance of its proposed standard, *Accounting for Certain Investments Held by Not-for-Profit Organizations*, if changes in market value were to be included within the operating measure. In addition, the classification of items as "operating" or "nonoperating" in accordance with our recommendation would be supported by paragraph 23 of FASB Statement No. 117, *Financial Statements of Not-for-Profit Organizations*.

Although current reporting practice provides greater comparability than the reporting practices proposed in the Exposure Draft, certain modifications to current requirements should be considered. Under current practice, the classification of items as "operating" or "nonoperating" is at the discretion of the individual health care provider. The same transaction may result in "operating" revenue or expense to one health care provider and "nonoperating" revenue or expense to another. As a result, some disparities have developed because the definition of ongoing, major, or central operations has varied among entities. This lack of uniformity in practice should be addressed by providing more specific guidance as to the definition of ongoing, major, or central operations versus peripheral or incidental transactions. Specific guidance could also include the type of transactions that would be reported as "nonoperating," such as investment results, contributions, and equity income.

Not-for-Profit Guide

Certain inconsistencies between the Exposure Draft and the Proposed Audit and Accounting Guide, *Not-for-Profit Organizations*, (the "NFP Guide") concern us. Under the NFP Guide, not-for-profit organizations that do not meet the FASB Statement No. 117 definition of a "not-for-profit organization" are required to follow generally accepted accounting principles (GAAP) with respect to pronouncements that conflict with the NFP Guide. The NFP Guide specifically refers to FASB Statement No. 115, *Accounting for Certain Investments in Debt and Equity Securities*. Many not-for-profit health care organizations do not meet the FASB Statement No. 117 definition of a not-for-profit organization and would be required to adopt FASB Statement No. 115 under the NFP Guide but not under the Proposed Health Care Guide. In addition, the NFP Guide

exempts certain not-for-profit organizations not meeting the FASB Statement No. 117 definition of a "not-for-profit organization" from the requirement for functional reporting. To avoid these inconsistencies, not-for-profit health care organizations that do not meet the FASB Statement No. 117 definition of a "not-for-profit" organization should be required to follow FASB Statement No. 115 and should be exempt from the requirement for functional reporting.

If you have any questions or if we can be of further assistance, please contact Val R. Bitton at (203) 761-3128 or Fred Heinzeller at (612) 397-4217.

Yours truly,

Deloitte & Touche LLP

APPENDIX

DELOITTE & TOUCHE LLP COMMENTS PROPOSED AUDIT AND ACCOUNTING GUIDE "HEALTH CARE ORGANIZATIONS"

Applicability

Paragraph 1.2 of the Exposure Draft indicates that not-for-profit, nonbusiness-oriented, health care organizations are voluntary health and welfare organizations as defined in FASB Statement No. 117, *Financial Statements of Not-for-Profit Organizations*, and fall within the scope of the AICPA Audit and Accounting Guide, *Audits of Not-for-Profit Organizations*, rather than the Exposure Draft. The distinction between not-for-profit, nonbusiness-oriented organizations and not-for-profit, business-oriented organizations (to which the Exposure Draft applies) is related to the amount of fees the organization receives for goods and services when compared to the amount of contributions it receives. The description of not-for-profit, business-oriented organizations indicates that they may receive "contributions of relatively small amounts". The Guide should clarify the level of contributions that would cause an organization to be categorized as business-oriented or nonbusiness-oriented. For example, some health care entities may receive contributions that are significant in absolute dollars, but small (e.g., less than 10%) relative to the total revenues of the organization. Also, an organization that typically receives "relatively small amounts" of contributions may receive a significant contribution in one year. The language in the first paragraph under "Applicability" in the preface, paragraph 1.2, and footnote 1 on page 63 of the Exposure Draft may require revision to more explicitly define the distinction between not-for-profit, nonbusiness-oriented organizations and not-for-profit, business oriented organizations.

The application of the Exposure Draft to governmental health care providers needs to be clarified. In the last paragraph under the heading "Applicability" in the preface, the Exposure Draft states that it is applicable (along with GASB pronouncements) to governmental health care organizations that use enterprise-fund accounting. The Sample Governmental Hospital financial statements included in the Exposure Draft incorporate most of the provisions of the Exposure Draft and of FASB Statement No. 116, *Accounting for Contributions Received and Contributions Made*, and FASB Statement No. 117, except that the term "fund balance" is used instead of the term "net assets". However, Governmental Accounting Standards Board Statement (GASB) No. 29, *The Use of Not-for-Profit Accounting and Financial Reporting Principles by Governmental Entities*, states, in paragraph 36 that "the revised guide (referring to the Exposure Draft) is expected to provide that...governmental entities should continue the same recognition for contributions received and made and the same financial statement display as provided for in the current health care guide." The guidance and reporting illustration in the Exposure Draft seem to be in conflict with the language in GASB Statement No. 29. The applicability of the Exposure Draft to governmental providers should be clarified when the Exposure Draft is issued in final form.

Premium and Capitation Revenues

Paragraphs 1.10, 1.19, 10.3 and 10.15 of the Exposure Draft require that capitation payments be reported as premium revenue and not as patient service revenue. We believe that revenue earned by health care providers under capitation arrangements with prepaid health care plans represent prepayments for patient care and should be reported as a component of patient service revenue. We agree that premium revenue earned by health maintenance organizations should be reported separately from patient service revenue.

Typically, capitation contracts cover an annual period and require monthly payments. If the services rendered by the health care provider occur ratably over the period of the contract, there will be an appropriate matching of revenues and expenses. However, if services under the contract fluctuate based on seasonality or other factors, recording revenue on a monthly basis may not result in appropriate matching. Paragraph 1.19 should be expanded to indicate that seasonality or other expected fluctuations of health care services should be considered in the recognition of revenues from a capitation contract. This would be consistent with other literature on service revenue -- for example, FASB Technical Bulletin No. 90-1, *Accounting for Separately Priced Extended Warranty and Product Maintenance Contracts*, and AICPA Statement of Position 91-1, *Software Revenue Recognition*. Those documents require straight-line recognition of service revenue except in circumstances where historical evidence indicates that services incurred under the contract are incurred on other than a straight line basis.

Investments

Changes in valuation allowances associated with investments held by health care organizations should not be included in operating income in the Statement of Operations; they should be treated in a manner similar to the items described in paragraph 10.13. Additionally, Chapter 4 should be expanded to address the use of valuation allowances for debt securities when such debt securities are reported at the lower of cost or market value.

Chapter 4 also should provide specific guidance on the classification of investments to clarify how equity and other securities should be grouped into current and noncurrent classifications. Footnotes to the illustrative financial statements for Sample Not-for-Profit Hospital discuss long term investments only in the context of debt securities and donor-restricted endowment gifts.

Retrospectively Rated Insurance Contracts

Paragraphs 8.14 and 8.15 of the Exposure Draft discuss the accounting for insurance premiums under retrospectively rated insurance policies. The final Guide also should address multiple-year retrospectively rated insurance contracts and should reference EITF Issue 93-14, *Accounting for Multiple-Year Retrospectively Rated Insurance Contracts by Insurance Enterprises and Other Enterprises*, for additional guidance in this area.

Operating Income

We agree that the items listed in paragraph 10.13 of the Exposure Draft should not be part of operating activities reported in the Statement of Operations, but should be shown outside of the

operating measure. The last sentence of paragraph 10.14 seems to imply that it is permissible to report certain activities outside the operating measure in addition to those mentioned in paragraph 10.13. The intent of paragraph 10.14 should be clarified to indicate whether items other than those listed in paragraph 10.13 may be reported outside of operating results. If so, guidance on what criteria would need to be met and any other considerations concerning classification of these items should also be provided.

If the contribution of long-lived assets is required to be reported separately from operations, as stated in paragraph 10.13, the same treatment should apply to the presentation of the expiration of donor-imposed restrictions on long-lived assets. The receipt of long-lived assets as a contribution and the receipt of cash or other assets that have been restricted by the donor for the acquisition of long-lived assets are substantially similar and should have similar financial statement presentation. In addition, the recognition principles of FASB Statement No. 116 regarding the expiration of donor-imposed restrictions on long-lived assets should be followed. FASB Statement No. 116 permits preparers to recognize the expiration of donor-imposed restrictions on long-lived assets either (1) when the asset is placed in service or (2) over the useful life of the asset. The Exposure Draft eliminates the latter option by requiring that the expiration of the restriction be recognized when the asset is placed in service (paragraph 10.9).

Combined Financial Statements

Chapter 11 of the Exposure Draft deals with the reporting entity and related organizations and provides guidance concerning when consolidated financial statements may be appropriate. Paragraph 11.4 of the Exposure Draft indicates that there may be circumstances where combined financial statements involving commonly controlled entities are more meaningful than their separate financial statements. Paragraph 11.17 states, "This guide prohibits consolidated financial statements in certain circumstances. However, it provides no guidance covering combined financial statements of commonly controlled entities..." The Guide should clarify that combined financial statements should not be used unless they are more meaningful than the separate financial statements.

Control Through Majority Voting Interest

Footnote 3 of Chapter 11 illustrates the term "majority voting interest" in the board of another entity. The footnote should clarify that under existing GAAP Entity A has control through a majority voting interest on the board only if Entity A has the contractual right to appoint board members of Entity B. If the FASB proceeds with its consolidations policy and procedures project to require consolidation when effective control exists, additional guidance may be needed for situations where board control exists without a contractual right.

Economic Interest

Paragraph 11.9 states, in part, that an economic interest exists when "[t]he reporting entity assigns certain significant functions to another entity." The meaning of this statement should be clarified in the Guide. For example, would a health system parent with a mission to provide health care services to the local community be deemed to have an economic interest in

corporations (such as a hospital or a nursing home) that it has designated to carry out its mission or would certain other conditions have to exist such as the transfer of significant resources?

Equity Transfers

The discussion of equity transfers in Chapter 11 should be expanded to provide guidance for certain transactions that occur frequently in the health care industry. Additional guidance should be provided on whether the following types of transfers would be considered equity transfers or charges to expense:

- Transfers made to an entity that is not wholly-controlled or wholly-owned. For example, two not-for-profit hospitals form a not-for-profit joint venture to provide health care services to an indigent population. Both hospitals provide working capital to the joint venture. In view of the joint venture's mission and operations, repayment of the transfers is not expected.

- Recurring transfers of resources to another entity that, in effect, are continuing subsidies of the other entity's operating losses. For example, a hospital makes cash transfers to a controlled community service organization to finance the organization's ongoing losses. Projections for the organization indicate continuation of losses, which will continue to be funded by the hospital.

We believe both of the above transfers should be considered charges to expense.

Business Combinations

Paragraph 11.28 of the Exposure Draft addresses the accounting for business combinations. The Exposure Draft states that a change in control, such as a change in the sole corporate member, should be accounted for similar to a pooling of interests transaction under APB Opinion No. 16, *Business Combinations*. The term "similar to a pooling of interests" should be clarified. Should the criteria specified by APB Opinion No. 16 be strictly followed and, if not, where should the accounting be allowed to differ? For example, should prior period financial statements always be restated to reflect the combination?

Illustrative Financial Statements

The illustrative financial statements present a diversity of reporting practices; however, it would be helpful to expand the illustrative financial statements of Sample Not-for-Profit Hospital to include certain transactions not presently shown, such as the following:

- Investment gains/losses and valuation allowances

- Investment transactions and disclosures in conformity with the proposed FASB standard on *Accounting for Certain Investments Held by Not-for-Profit Organizations* (if issued before the Guide is issued)

- Consolidation by a not-for-profit health care organization of a for-profit subsidiary with investments accounted for under FASB Statement No. 115, *Accounting for Certain Investments in Debt and Equity Securities.*

- Disclosure of risks and uncertainties in accordance with AICPA Statement of Position 94-6, *Disclosure of Certain Significant Risks and Uncertainties.* A more comprehensive disclosure example should be provided than is presently shown.

- Unrestricted gains on investments of permanently restricted net assets. The present disclosure under the heading "Temporarily and permanently restricted net assets" in Note 1 is not specific regarding the treatment of these types of gains and losses.

- Premium revenue derived from capitation arrangements with related footnote disclosure, if our recommendation to include capitation revenue as a component of patient service revenue is not adopted.

- Contributions received by an unconsolidated foundation for the benefit of the provider that are accounted for as an agency transaction.

In addition to the above, the notes to the illustrative financial statements present examples of functional reporting, but in most instances merely indicate that several functions may be reported without specifying what they are (they are usually shown as function A, B, C, etc. - See Note 10, page 132; Note 7, page 150; Note 8, page 159; Note 9, page 167 and Note 6, page 173). We suggest that the notes show actual functions that may be used for expense reporting.

Effective Date

The effective date is for financial statements for periods beginning after June 15, 1995. In view of the delay in issuing the Exposure Draft, we suggest that the effective date be moved to the issuance date.

Differences Between the Exposure Draft and FASB Statement No. 117

The Exposure Draft appears to be more restrictive than FASB Statement No. 117 in several areas, including the following:

- The use of current/non-current classification for the balance sheet

- The classification of revenues, expenses, gains and losses in the statement of operations

- The reporting of contributions of long-lived assets

In the hierarchy of generally accepted accounting principles, FASB standards provide the highest level of guidance. If the FASB concurs that the Exposure Draft should govern reporting in the areas mentioned above, a statement should be made to that effect. Without such a statement it is possible that there will be confusion during implementation of the Guide.

Reference to Not-for-Profit Organizations Audit and Accounting Guide

Existing accounting and reporting matters that health care organizations may need to address as a result of FASB Statement No. 116 are not addressed in the Exposure Draft (e.g., extensive discussions of contributions, including distinctions between contributions, exchange transactions and agency transactions, and guidance concerning endowment funds, split-interest agreements, and contributed services). In order to assure that preparers of financial statements refer to the appropriate guidance, the Exposure Draft should include language referring readers to the NFP Guide with respect to those transactions.

Statement of Activities

References to a statement of activities are made in paragraphs 10.7, 10.8 and 10.9 of the Exposure Draft but the statement is not defined. Included in the appendix are examples of statements of operations, statements of changes in net assets, statements of income and retained earnings and others. The appendix does not include a statement of activities. Either the Exposure Draft should clarify the definition of a statement of activities or the illustrative examples in the appendix should indicate which statements might be considered statements of activities.

* * * * * *

August 30, 1995

Annette J. Schumacher, Technical Manager
File H-1-500, Federal Government Division
American Institute of Certified Public Accountants
1455 Pennsylvania Avenue, NW
Washington, DC 20004-1081

Dear Ms. Schumacher:

The Committees on Auditing Services and Accounting Principles of the Illinois CPA Society ("Committees"), assisted by the Health Care Committee, are pleased to have the opportunity to comment on the exposure draft of the Proposed Audit and Accounting Guide, Health Care Organizations ("Exposure Draft") of the American Institute of Certified Public Accountants ("AICPA"). The organization and operating procedures of the Committees are described in the appendices to this letter. These recommendations and comments represent the position of the Illinois CPA Society rather than any of the Committee and of the organizations with which they are associated.

The Committees support the issuance of the Audit Guide and urge its issuance at an early date to provide guidance for CPA's that audit health care organizations. However, we do have some suggestions for revision we hope you will consider seriously before issuance. The following are our major concerns.

1. Paragraph 8.33, in discussing the audit of accounting estimates of claims incurred but not reported, suggests using the entity's prior history as support for management's estimate. Guidance (alternate procedures) for auditing new entities that have no prior history should be provided. We suggest including a discussion of the circumstances in which a lack of prior history might result in an audit scope limitation. In addition, we suggest including a sample scope limitation report in Chapter 12 (Independent Auditor's Reports).

2. Paragraphs 2.49 and 2.50 refer to OMB Circulars A-128 and A-133 and include the dollar thresholds contained therein. We believe that either (1) specific federal regulations, such as OMB circular numbers and dollar thresholds, should not be included in the Guide because the Circulars are amended and the thresholds change or the Circulars themselves disappear (for instance, we expect that OMB Circular A-128 will be folded into A-133); or (2) the Health Care Committee should plan to timely amend the Guide for changes in the specific regulations.

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Further, we suggest including a discussion in paragraphs 2..49 and 2.50 of the possibility that an independent auditor might be engaged to perform a program specific audit in accordance with an audit guide. Audit guides may contain thresholds different from the OMB Circulars (e.g., the HUD audit guide uses a $300,000 threshold) and, since these thresholds are also subject to change, perhaps the dollar thresholds should not be included in this discussion.

3. Issue 1, as written, indicates that the purpose of the limitation is to achieve consistency of reporting for not-for-profit health care organizations. We noted that the proposed new accounting and audit guide for not-for-profit organizations (excluding health care organizations) does not contain the same restrictions indicated here. Accordingly, we suggest reconsideration of the underlying reasons for this difference to determine whether the determining factor was either the nature of the health care industry or the nature of not-for-profit organizations. If the determining factor was the latter, we suggest that the two proposed guides be consistent.

4. We agree with the Guide's position (Issue 2) that changes in the valuation allowance should be included above the operating income caption in the statement of operations, if investment income is also classified above that caption. We do, however, suggest that, for those organizations who wish to separate health care activity from investment activity, the statement of operations include a subtotal caption entitled "operating income before investment revenues (expenses)," followed by the investment revenue and expense display and then followed by a subtotal caption entitled "operating income."

We would be pleased to discuss our comments and recommendations with you at any time.

Very truly yours,

Joan E. Waggoner

Sharon J. Gregor
Chair of Committee on Auditing Services

Joan E. Waggoner
Chair of Committee on Accounting Principles

APPENDIX A

ILLINOIS CPA SOCIETY
ACCOUNTING PRINCIPLES COMMITTEE
ORGANIZATION AND OPERATING PROCEDURES

1995 - 1996

The Accounting Principles Committee of the Illinois CPA Society (the Committee) is composed of 29 technically qualified, experienced members appointed from industry, education and public accounting. These members have Committee service ranging from newly appointed to 15 years. The Committee is a senior technical committee of the Society and has been delegated the authority to issue written positions representing the Society on matters regarding the setting of accounting principles.

The Committee usually operates by assigning a subcommittee of its members to study and discuss fully exposure documents proposing additions to or revisions of accounting principles. The subcommittee ordinarily develops a proposed response which is considered, discussed and voted on by the full Committee. Support by the full Committee then results in the issuance of a formal response, which at times, includes a minority viewpoint.

ERNST & YOUNG LLP

787 Seventh Avenue
New York, New York 10019

Phone: 212 773 3000

September 12. 1995

Ms. Annette J. Schumacher
Technical Manager
Federal Government Division
American Institute of Certified Public Accountants
1455 Pennsylvania Avenue, NW
Washington, DC 20004-1081

Proposed Audit and Accounting Guide,
"Health Care Organizations"
(File H-1-500)

Dear Ms. Schumacher:

We are pleased to provide comments on the above-referenced proposal. We support the issuance of the proposed Audit and Accounting Guide (the Guide). The Guide will provide useful implementation guidance relating to FASB Statements No. 116, *Accounting for Contributions Received and Contributions Made*, and No. 117, *Financial Statements of Not-for-Profit Organizations*, and therefore should be issued as soon as practicable. Our responses to the issues raised in the Exposure Draft (ED) follow.

Issue 1

The proposed method of accounting for the expiration of donor-imposed restrictions on long-lived assets would require that not-for-profit health care organizations recognize those expirations when the asset is placed into service, which is more restrictive than Statement 117. Statement 117 allows not-for-profit health care organizations the option of recognizing the expiration of donor-imposed restrictions either when the asset is placed into service or over the useful life of the asset. We agree that by recognizing expirations when the asset is placed into service, the effect of depreciation expense would be reflected as a decrease in unrestricted net assets over the useful life of the asset. The proposed method therefore would result in comparable operating measures between not-for-profit health care organizations and their for-profit counterparts, and we support that method.

Issue 2

If the FASB adopts the method proposed in its exposure draft, *Accounting for Certain Investments Held by Not-for-Profit Organizations*, the Guide would require most

unrealized gains and losses on debt and equity securities held by not-for-profit health care organizations to be included above "operating income" in the statement of activities. In our comment letter to the FASB, we stated that we do not support the Board's proposal that would require investments in marketable equity securities and all debt securities to be measured at fair value, with unrealized gains and losses reported in the statement of activities. Rather, we believe that the accounting model for not-for-profit health care organizations should be consistent with the model established by FASB Statement No. 115, *Accounting for Certain Investments in Debt and Equity Securities*, that requires investments to be classified into one of three categories—trading, available-for-sale, and held-to-maturity. However, if the FASB issues its final standard with only one class of investments, and those investments are recorded at fair value, we believe unrealized gains and losses should be reported as a change in net assets below the operating indicator line. In our view, the operating indicator line should reflect the operations of the entity—that is, the revenues for services provided and related costs, not unrealized investment gains and losses that are incidental to the operations of a health care organization.

As proposed, the effective date of the Guide would be for periods beginning after June 15, 1995. In light of current expectations regarding when the final Guide will be issued, we believe the effective date of the Guide should be delayed until years beginning after June 15, 1996. This will give health care organizations sufficient time to understand the provisions of the Guide and evaluate its effects on their financial statements.

Attachment A to this letter includes our comments on other specific issues.

We appreciate the opportunity to present our views on the ED and would be pleased to discuss our letter with AcSEC or the AICPA staff at your convenience.

Very truly yours,

Ernst & Young LLP

Attachment A

"Health Care Organizations"

Other Comments on Specific Issues

Paragraph	Discussion
3.1	Consistent with Statement 117, this paragraph indicates that cash that is subject to donor-imposed restrictions is to be reported separately and excluded from cash and cash equivalents. We believe cash that the Board or management has designated for future use (e.g., for future capital expansion or retirement of long-term debt) also should be reported separately as a noncurrent asset, and the nature of the internal limitation should be separately disclosed. Our view is consistent with Accounting Research Bulletin No. 43, *Restatement and Revision of Accounting Research Bulletins*, that states, "(t)his concept of the nature of current assets contemplates the exclusion from that classification of such resources as: (a) cash and claims to cash which are restricted as to withdrawal or use for other than current operations, are designated for expenditure in the acquisition or construction of noncurrent assets, or are segregated for the liquidation of long-term debts ... ."
5.14	This paragraph states that "pledges and other promises with payments due in the future are to be reported based on the present value of estimated future cash flows using a discount rate commensurate with the risks involved." Consideration should be given to providing additional guidance on determining the appropriate discount rate, similar to the guidance set forth in paragraph 5.54 of the Exposure Draft, *Not-for-Profit Organizations*, that states, "(t)he present value of estimated future cash flows using a discount rate commensurate with the risks involved should be measured as the present value of the amounts expected to be collected, using a risk-free rate of return considering the life of the promise to give."
6.13	Exhibit 6.1 illustrates auditing objectives, selected control procedures, and auditing procedures for financial statement assertions about fixed assets. This exhibit should include a discussion of the factors that auditors should consider in determining whether the provisions of FASB Statement No. 121, *Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to Be Disposed Of*, have been complied with.

10.14

Statement 117 allows not-for-profit health care organizations to classify items as operating and nonoperating, expendable and nonexpendable, earned and unearned, recurring and nonrecurring, etc. We believe that the Guide also intended to provide this flexibility. Accordingly, the Guide should be clarified to specifically allow additional classifications within the statement of activities and to require that if an intermediate classification is used, and its use is not apparent from the details provided on the face of the statement, the nature of the intermediate measure should be disclosed in a footnote.

11.10

This paragraph indicates that consolidation is appropriate when an organization has a controlling financial interest in another entity through direct or indirect ownership or a majority voting interest, except when control is likely to be temporary or when control does not rest with the majority owner. Footnote 2 discusses when control does not rest with the majority owner and includes when "... the sole corporate member's interest in the controlled entity is restricted by state law." Consideration should be given to the impact of restrictions that arise from contractual agreements that also may indicate a lack of control.

11.27

The sixth bullet point of this summary discusses the treatment when an entity has control over another organization or has an economic interest in the other organization, but not both. The requirement should state that consolidation is prohibited, and the disclosures set forth in FASB Statement No. 57, *Related Party Disclosures*, are required, as provided in paragraph 11.13 of the Guide.